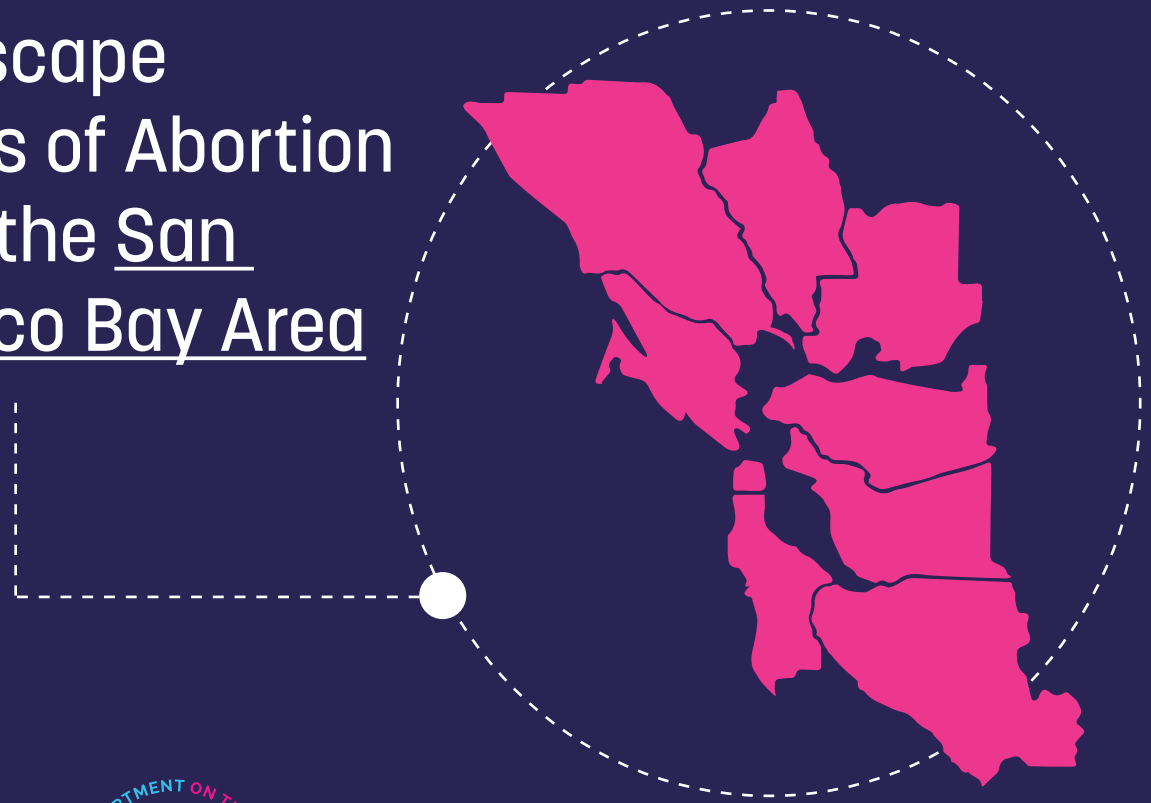
PREPARING FOR AN UNCERTAIN FUTURE IN POST-DOBBS AMERICA

A Landscape Analysis of Abortion Care in the San Francisco Bay Area



GENDER EQUITY POLICY INSTITUTE

SAN FRANCISCO DEPARTMENT ON THE STATUS OF WOMEN

Preparing for An Uncertain Future in Post-Dobbs America

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GE PI GENDER EQUITY POLICY INSTITUTE

SAN FRANCISCO DEPARTMENT ON THE STATUS OF WOMEN

Sponsor's Letter

Dear Reader,

In these turbulent times, where reproductive freedoms are under unprecedented attack, it is imperative that we, as a community, rise to meet these challenges with unwavering resolve and collaborative action. To that end, I am honored to present this comprehensive report on the state of reproductive rights and abortion care in the San Francisco Bay Area.

This report, funded by San Francisco's Department on the Status of Women, underscores the urgent need for the Bay Area to champion abortion rights and serve as a sanctuary for all women and individuals seeking reproductive or sexual healthcare services. The findings of this report illustrate the stark reality of the current landscape and the critical role our region must play in ensuring equitable access for all.

INTERSECTIONALITY OF ABORTION CARE

Abortion care is not just a health issue; it is a matter of economic security and justice. The ability to access safe and legal abortion services is inextricably linked to a person's ability to control their economic future. Women denied abortions are more likely to experience economic hardship, increased risk of intimate partner violence, and poorer physical and mental health outcomes. Moving forward, we must recognize and address these intersecting issues to promote true reproductive freedom.

KEY TAKEAWAYS

1. Increased Demand and Strain on Services:

- The Bay Area has seen a significant increase in the demand for abortion services post-Dobbs decision, placing a tremendous strain on our clinics and healthcare providers. Despite the robust infrastructure, the rising need is pushing facilities to their limits.

2. Disparities in Access and Outcomes:

- The report highlights that Black women face the highest rates of poverty (15.4%) and the lowest median incomes ($72,000) among all racial groups in the Bay Area, which directly impacts their ability to access reproductive health services. This disparity is a glaring indicator of the broader systemic inequities that we must address.

3. Economic Impact of Denied Abortions:

- Women who are denied abortions are four times more likely to live below the poverty line and three times more likely to be unemployed. This economic insecurity not only affects the individuals but also their families and communities, perpetuating cycles of poverty and disadvantage.

4. Legal and Safety Concerns for Providers:

- Our healthcare providers are facing increased legal risks and harassment, with many expressing uncertainties about their protections under current laws. This hostile environment is not only a barrier to care but a direct threat to the safety and well-being of those dedicated to providing essential health services.

5. Regional Coordination and Advocacy:

- The need for a coordinated regional approach is clear. The fragmentation of efforts across different counties and organizations limits our ability to effectively address the challenges. A unified strategy that includes government entities, advocates, and providers is essential for creating a resilient and responsive regional reproductive healthcare system.

CALL TO ACTION

The data and insights presented in this report should serve as a clarion call for immediate action. We must forge stronger partnerships and work collectively to dismantle the barriers to access and care; and our elected officials, policymakers, and advocates all have a role to play in this endeavor. We must leverage our collective strength to ensure that every individual has the freedom and support to make decisions about their reproductive health without fear or hindrance.

Finally, this report is not just a collection of data - it is a testament to the tenacity and dedication of our community. It is a call to arms for all of us to stand firm in our commitment to reproductive freedom and justice. The San Francisco Bay Area has the resources, the expertise, and the will to lead the nation in protecting and advancing abortion rights. If there's one thing we've learned in the last few years, it's that this is not a drill. It's go time.

Thank you for your continued support and dedication to this intersectional issue that touches every facet of our individual and collective lives. Together, we can and must make a difference.

Sincerely,

Kimberly Ellis
Director, San Francisco Department on the Status of Women

September 2024

Acknowledgements

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Executive Summary

Nearly seven in ten Californian adults believe that abortion should be legal in all or most cases.[1] Since the Supreme Court eradicated the constitutional right to abortion in the 2022 Dobbs decision, 15 states have banned abortion and an additional seven have imposed bans before 18 weeks of gestation.[2] Tens of millions of American cis women and girls now live in states that deprive them of agency, bodily autonomy, and the right to make their own decision about if and when to have children.[3]

Despite widespread American support for reproductive freedom, the anti-abortion movement continues to pursue a national abortion ban. It has unveiled plans to ban abortion through executive action without any Congressional oversight or approval. Should Republican nominee Donald J. Trump win the presidency in 2024, he will likely seek to impose a national abortion ban, as evidenced by his statements taking credit for appointing the Supreme Court Justices who overturned Roe v. Wade.

Since Dobbs, women have been denied care and have suffered grievous health complications. Rape victims and young teens have been forced to give birth because they lived in a state that bans abortion even in cases of rape, incest, or the health of the mother. [4] Many more of these stories have gone unreported and untold. As one physician reflected, these are "the absolutely terrible, horrific circumstances we're in now."[5]

Yet in contrast to states that rushed to impose extreme abortion bans, California acted boldly from the start to establish itself as a haven for abortion care access.

In November 2022, California voters approved Proposition 1, a constitutional amendment to guarantee the right to abortion and contraception. The legislative sessions of 2022 and 2023 yielded increased funding to support abortion care access and laws to strengthen legal protections, as well as to expand equitable abortion care access for Californians and people facing restrictions in other states. Governor Gavin Newsom has championed reproductive freedom from his bully pulpit, issued executive orders protecting rights, and helped secure significant state funding to support abortion and reproductive healthcare access.

Regionally, the Bay Area also moved swiftly to protect reproductive freedom, rights, and justice, launching the San Francisco Bay Area Abortion Rights Coalition (BAARC) in January 2023, developed and led by the San Francisco Department on the Status of Women, with support from San Francisco Mayor London Breed and the Board of Supervisors. On June 18, 2024, Mayor London Breed put forward the San Francisco Reproductive Freedom Act, a ballot measure to ensure the reproductive freedoms and rights of everyone within the City remain protected. The BAARC initiative is a regional collective of municipal and county governments and reproductive health and justice stakeholders committed to

reinforcing the local reproductive healthcare delivery system in the post-Dobbs era. Nine counties are participating in the initiative: Alameda, Contra Costa, Marin, Napa, Santa Clara, San Francisco, San Mateo, Solano, and Sonoma.[6] Also participating in the initiative are practitioners, stakeholders, and leaders in reproductive health, freedom, and justice.

The Bay Area is home to a vibrant, diverse, and dedicated community of sexual and reproductive healthcare providers, reproductive freedom and justice advocates, and an abundance of research, technology, legal, and medical institutions. This community has rallied around the effort to restore, safeguard, and expand abortion care access to Californians, as well as to provide a safe haven in the Bay Area for women who live in banned states.

"**Preparing for An Uncertain Future in Post-Dobbs America**" presents the results of research by the Gender Equity Policy Institute, initiated and funded by the San Francisco Department on the Status of Women. This report provides foundational research and actionable recommendations to enable the BAARC initiative to best serve the Bay Area community, participate effectively in local, state, and federal policy debates, and establish itself as an effective multi-sector, multi-jurisdictional collaborative to guarantee reproductive freedom, rights, and justice in the region.

The findings presented here are drawn from research conducted from June 2023 through May 2024, which included focus groups with abortion care clinicians and people who provide practical support throughout the Bay Area, interviews with medical and legal experts and community stakeholders, a review of the national and global literature on sexual and reproductive health (SHR), and analysis of demographic and socioeconomic data on the region's population of reproductive-age women.

There is wide consensus that abortion and comprehensive sexual and reproductive healthcare should be of high-quality, affordable, equitable, and accessible to all people.[7]

Our research shows that the Bay Area has a strong infrastructure for delivering high-quality sexual and reproductive healthcare. In the region, increased demand for abortion care is being met, thanks to the dedication of medical providers and advocates and the financial support they have received from the State and the City and County of San Francisco.

Nevertheless, the increased demand for care is putting a strain on clinics, medical facilities, and abortion care clinicians and staff. Nonprofit and volunteer organizations that provide indispensable support to patients are also working at full capacity. In interviews and focus groups, these people on the frontlines of abortion care in the Bay Area have shared

the major challenges they face and identified specific ways that the BAARC initiative and state policymakers can support their work and safeguard access to abortion and reproductive healthcare.

In sum, the Bay Area has many of the necessary foundations in place for delivering high-quality, affordable, equitable, and accessible abortion care. A wide body of scientific and medical research concludes that protecting reproductive freedom and supporting full and equitable access to abortion protects the health and well-being of women, people who can become pregnant, and their babies. (See Part 2.) Our aim in this analysis of the landscape of abortion care in the San Francisco Bay region is to bolster the efforts of policymakers and stakeholders to safeguard and improve reproductive health and justice for Bay Area residents, as well as to provide a safe haven to all people deprived of fundamental reproductive freedom in post-Dobbs America.

We conclude this report with recommendations in five areas, summarized here and detailed in Part 6.

1. REGIONAL SYSTEMS COORDINATION AND INFORMATION SHARING

A clear consensus emerged among members and affiliates of BAARC: the most important benefit of the initiative is information sharing and systems coordination across the region. Every sector currently involved in BAARC identified opportunities in this area.

- Prioritize community engagement, connect with communities through trusted advocates, and include community groups as full partners.
- Provide topic-specific trainings (by webinar) to build knowledge and capacity across sectors throughout the region.
- Share information about successful local programs and develop toolkits or topical resource guides to facilitate regional replication.
- Establish mechanisms, such as workgroups, quarterly meetings, and newsletters, to build connections and community among BAARC initiative participants.
- Enlist Bay Area participants and statewide groups like Essential Access Health and CCRF to help expand the coalition.

2. COORDINATION OF CARE AND LOGISTICS OF ACCESS

Clinicians who provide abortion services stressed the need for better coordination of care. Throughout the region, the community of healthcare professionals and advocates have developed innovative solutions, but efforts are fragmented and siloed. Building an infrastructure for care coordination can help identify and scale these solutions, as well as innovate new linkages and systems. Closely related to the need for medical care coordination is support for managing the logistics of access, whether it is scheduling travel, arranging

lodging/childcare, paying for a procedure, or navigating insurance coverage.

- Create a central hub for care coordination to help ensure patients receive care at appropriate facilities based on their medical needs.
- Develop plans and policies to address the difficulty women and providers have in enrolling in pregnancy-specific Medi-Cal to pay for abortion care.
- Provide logistical and technical assistance to patient-supporting organizations, such as abortion funds.
- Develop plans to assess region-wide logistical needs and attract funding for practical support from public and/or philanthropic sources.
- Work with agency partners to ensure patients are aware of all resources for care and practical support.

3. SECURITY, PRIVACY, AND LEGAL PROTECTION

Regional coordination on legal issues can be critical in addressing the significant concerns providers, patients, and advocates have about their personal security, digital privacy, and vulnerability to civil or criminal legal action by states that ban abortion.

- Coordinate regionally on law enforcement matters, including the Attorney General's Reproductive Justice Unit in BAARC's efforts.
- Conduct assessment of all locations where anti-abortion protests are interfering with care to develop action plans.
- Develop model local ordinances.
- Develop or host training programs for local law enforcement.
- Develop and share guidelines and best practices for permitting abortion clinics.
- Improve systems to protect physical and digital security of abortion care providers.

4. OUTREACH, EDUCATION, AND COMMUNICATIONS

Through public health communications, initiatives like BAARC can help ensure that public dialogue about abortion and reproductive healthcare remains grounded in science and evidence.

Likewise, many of BAARC's larger objectives can be advanced through outreach, public education, and communications. Such efforts should be developed in close coordination with the community, as well as with physicians, researchers, and legal experts. Private-public partnerships can be particularly beneficial in this domain.

- Publicize more widely the existing resources about abortion and reproductive healthcare in California, such as abortion.ca.gov.

- Conduct public information campaigns and outreach within marginalized communities about the availability of free and low-cost abortion care in California, as well as how to access it.
- Develop an information campaign around telemedicine and medication abortion to help people know where to go when they need to access care.
- Amplify the voices and stories of people who have had abortions.
- Develop a plan to assess whether healthcare providers in the region are receiving comprehensive implicit bias training to ensure that all patients, including those coming from other states, receive care that makes them feel safe and respected.
- Promote, defend, and amplify a scientific, evidence-based approach to abortion and reproductive healthcare.
- Engage the Bay Area's tech community in reducing disinformation about SRH and abortion on social media platforms and in search results.
- Publicize scientifically accurate information about abortion to counter medically false information promulgated by the anti-abortion movement.

5. POLICY COORDINATION AND ADVOCACY

The barriers to high-quality, affordable, equitable, and accessible abortion care in the region, in many instances, can most effectively be addressed at the state level in alliance with other state and local reproductive freedom and justice policy networks.

- Collaborate with existing policy networks, such as the California Future of Abortion Council and California Coalition for Reproductive Freedom, to identify policies relevant to the Bay Area.
- Explore designating a BAARC representative to the FAB Council and a FAB Council member to BAARC to facilitate rapid information sharing.
- In advocacy with elected officials, promote the use of a scientific knowledge base in policymaking and decision-making about abortion.
- Include SRH researchers and physicians who provide abortions in crafting policy related to medical procedures in order to avoid vague or difficult to operationalize provisions.
- Require community college student health centers to provide the full range of reproductive healthcare services, including medication abortion, as is now the practice in the University of California and California State University systems.

Introduction

The San Francisco Bay Area Abortion Rights Coalition (BAARC) initiative, developed and led by the San Francisco Department on the Status of Women (DOSW) with support from Mayor London Breed and the Board of Supervisors, is a regional collective of municipal and county governments and reproductive health and justice stakeholders committed to safeguarding and reimagining the local abortion and reproductive healthcare delivery system in the post-Dobbs era.

The initiative was designed to minimize harm from the Dobbs ruling for abortion care patients and providers, prepare for an influx of people traveling from banned states, and spearhead a coordinated response to proliferating state restrictions on abortion and the threat of a national ban.

To better understand abortion care, wraparound services, and practical support available throughout the region and to identify gaps and needs, DOSW provided a grant to the Gender Equity Policy Institute, a nonprofit research institute, to conduct a landscape assessment of the region's abortion care delivery system.[8]

The analysis presented here is guided by four interwoven principles for delivering abortion care and advancing reproductive justice and freedom more broadly.[9]

- **Quality**: high-quality, comprehensive SRH should be based on the best available scientific evidence and be delivered with respect and compassion.
- **Affordable**: comprehensive SRH should be fully covered by private or public health insurance and available to patients with minimal or no out-of-pocket cost.
- **Equitable**: comprehensive SRH should be equally and equitably available to all people, regardless of gender or sex, gender identity, ethnicity/race, age, income, immigration status, disability, zip code, language, or other identity.
- **Accessible**: comprehensive SRH should be easily accessible by law and in practice.

Through focus groups, interviews, and data analysis, we examined:

- The policy and political environment for protecting reproductive rights and the legal risks to members of the community aiding out-of-state patients.
- Looming threats to abortion access in the region posed by the national anti-abortion movement.
- Assets and strengths within the region for delivering high-quality, affordable, equitable, and accessible abortion care.
- Challenges to providing abortion care for women in the region, for those in nearby

regions of California, or for those traveling from banned states to the region to obtain abortion care.

- Barriers faced by patients, with particular attention to those stemming from disparities based on intersecting identities, such as race/ethnicity, age, income, disability, and immigration or housing status.
- The concerns, needs, and recommendations of providers, patients, and advocates.
- The importance of wraparound services and practical support to reducing barriers to equitable access to abortion care.

"**Preparing for An Uncertain Future in Post-Dobbs America**" catalogues assets and resources in the region for abortion care service delivery, highlights programs and policies that are working, analyzes gaps and needs, and presents actionable recommendations to address those gaps.

Part 1 places the current tenuous state of reproductive rights in the United States in a global perspective, reviews the supportive legal and policy landscape in California, and examines specific challenges from anti-abortion forces in the Bay Area. It includes a section, "Resources: Know Your Rights And Find Legal Assistance."

Part 2 examines abortion as a critical element of care on the continuum of sexual and reproductive healthcare. Part 3 presents a socioeconomic and demographic profile of reproductive-age women in the Bay Area. Included in this section are specific data analyses and visualizations for each of the nine counties participating in the initiative.

The findings from our focus groups and interviews with abortion care providers, advocates, and practical support providers are covered in depth in Part 4, where we pay particular attention to issues of equity and affordability. This section includes information about out-of-state patients in the Bay Area.

Part 5 explores several innovative initiatives, as a way of providing models and resources for the initiative. The key recommendations for action for BAARC are presented in Part 6.

PART 1

Law and Policy

The Legal Landscape of Reproductive Rights

In 2022, the Supreme Court eradicated the constitutional right to abortion established in Roe v. Wade that had stood for nearly 50 years. Within the two years since the Dobbs decision, 15 states have banned abortion from conception or up to six weeks of pregnancy. Another seven have imposed bans before 18 weeks of gestation.

With the Dobbs decision, the United States joined only a handful of countries that in recent years have rolled back abortion rights. Over the last three decades, 59 countries have expanded the right to abortion, while only three (besides the U.S.) have further limited or restricted it: Poland, El Salvador, and Nicaragua.[10] In Europe, only six countries retain highly restrictive abortion laws and do not permit abortion on request or on broad social grounds.[11]

The different trajectory in the United States, compared to our neighbors in Latin America, is particularly illuminating. Historically, abortion has been highly restricted in Latin America. But in the last decade, a feminist movement to legalize abortion gained momentum. The "Green Wave" movement achieved its first victory in 2020, with Argentina's legalization of abortion. In 2022, Colombia followed suit. In 2023, the Supreme Court of Mexico struck down the nation's federal law criminalizing abortion and ruled that federal clinics and hospitals must offer abortion care.[12]

The United States is, thus, increasingly an outlier in the global context of reproductive rights and health. The recent Supreme Court decision in Idaho's challenge to the Emergency Medical Treatment and Labor Act (EMTALA) likewise signals that the current Court remains receptive to further restrictions on abortion access, regardless of the medical and scientific consensus on the importance of abortion care to women's health.

California in Post-Dobbs America

In the wake of Dobbs, California and other states acted to safeguard and expand access to abortion care.

California's policymakers (at every level) have enacted robust rights protections, authorized funding for SRH services, and launched innovative programs to safeguard and expand access to comprehensive sexual reproductive healthcare (SRH), of which abortion care is an essential component.

In 2021, the California Future of Abortion Council (FAB Council) was established. With

more than 40 organizational members, the FAB Council worked closely with the Newsom Administration and the California Legislative Women's Caucus to craft policies to strengthen legal protections of reproductive rights and expand access to abortion and reproductive healthcare, particularly for low-income women and communities of color.

Through the combined effort of the Governor, the legislature, and the advocacy of the FAB Council and its member groups, California enacted dozens of supportive measures in 2022 and 2023. Specifically, these executive orders and laws are designed to:

- Enhance legal protections from civil and criminal liability for providers and patients.
- Expand access to abortion care.
- Eliminate or reduce costs of abortion care and birth control.
- Expand the abortion and reproductive healthcare workforce.
- Provide medically accurate, comprehensive, and inclusive information on abortion and where to access care through a government supported web platform.

Some of these measures are particularly directed to the legal jeopardy faced by California clinicians and advocates who help residents of banned states secure abortions in California. The State has enacted policies protecting healthcare professionals from civil and criminal liability or professional sanctions. The shield law prohibits state employees from cooperating with a banned state's attempt to sanction a healthcare professional with pressure on California to revoke their license or subject them to criminal prosecution. Other laws address health records privacy, a measure reinforced by a recent Biden Administration executive order, to protect patients and those who provide abortion care alike.[13]

To support these measures, California allocated $200 million across several programs. The uncompensated care grant program provides funds to eligible Medi-Cal providers to enable them to provide abortion care and birth control at no cost to patients with income up to 400% of the federal poverty level and who do not have insurance. The practical support grant program disburses funds to community-based and nonprofit organizations to help patients cover the nonmedical costs of abortion care, such as transportation, lodging, childcare, and lost wages. The programs are available to both California residents and people traveling from restricted and banned states to access abortion care.

The State of California has successfully launched abortion.ca.gov, a website that provides a 'one-stop' platform for information about the legal rights of patients, how to pay for abortion care, where to get an abortion, types of abortion services, emotional health and wellbeing related to abortion care, and other useful resources. It is geared both toward Californians and out-of-state patients. Patients can enter a California zip code or view a map of the state to find an abortion provider. Search results include information on contacting clinics and providers, as well as what type of abortion care service is provided at the location.

No personal information or electronically collected personal information is stored on the abortion.ca.gov website. It is available in English, Spanish, Tagalog, Simplified Chinese, and Traditional Chinese. For instructions on accessing other languages, see https://abortion.ca.gov/translating-this-website/#other-languages

In 2024, the FAB Council partnered with the California Coalition for Reproductive Freedom (CCRF), a statewide member-led organization; CCRF became the administrator of the FAB Council. In the 2024 legislative session, CCRF and the FAB Council introduced a legislative package to advance reproductive freedom and justice in California. These measures are still making their way through the legislative process. The deadline for bills to be signed into law is September 30, 2024. The package includes bills to:

- Protect and expand equitable access to abortion services and related care.
- Increase patient access to sexual and reproductive healthcare services and resources.
- Reduce disparities in maternal health outcomes and seek justice for pregnant people.
- Support the reproductive health workforce and improve clinic infrastructure.
- Improve reproductive health equity.
- Support the needs and well-being of families.

In sum, the legal foundation is firmly in place to support the delivery of high-quality, equitable, affordable, and accessible abortion care. Funding from the State will be available until 2028 under current law.

The major challenge is successful implementation. The BAARC initiative can play a significant role in this work in two ways.

One, through internal collaboration and public education, it can ensure that residents know their rights, policies are implemented and enforced regionally, and community-based organizations are included in decision-making and supported in care delivery.

Two, the threats to reproductive freedom and rights from the national anti-abortion movement will continue for the foreseeable future. The BAARC initiative can leverage its collective voice and resources to advocate for local, state, and federal policy efforts. Detailed recommendations for BAARC can be found in Part 6.

California as a Safe Haven: Protecting the Right to Travel

Anti-abortion politicians in other states, having imposed state bans, have expressed a desire to punish women for seeking abortion care outside their state. Thus far, the only passed legislation concerns assisting minors in traveling across state lines.

While it is unclear if more states will attempt to restrict travel and if those laws would pass constitutional muster, California has enacted measures to protect the fundamental right to travel.

California prohibits law enforcement from sharing license plates with out-of-state law enforcement agencies. There is evidence, however, that some sheriffs' offices are not complying. In 2023, an investigation led by the Electronic Frontier Foundation and the Northern and Southern California American Civil Liberties Union (ACLU) found that more than 70 law enforcement agencies had shared data from Automatic License Plate Readers with other states, in violation of AB 1242. Santa Clara, Solano, Contra Costa, and Marin were among those in the Bay Area allegedly sharing license plates with states that restrict or ban abortion.[14]

Training, education, and accountability measures will all be needed to protect California providers and out-of-state patients. The BAARC initiative can serve as the coordinating table in the region for identifying specific local needs and developing shared training and legal resources.

Reproductive Rights and Freedom: Regional Considerations

For Bay Area policymakers, agency staff, and elected officials, the Dobbs decision and subsequent state abortion bans present a new governing challenge. Previously, regional and municipal agencies not involved in health services had little reason to be involved in or informed about reproductive healthcare. Now, these agencies find themselves drawn into the challenge of providing support, resources, and legal protection for patients and providers. For example, law enforcement agencies may be faced with requests from states that ban abortion to assist in identifying or apprehending patients and clinicians who provide abortion; they need to be trained on the recent California laws that prohibit sharing this information. Planning departments and local elected officials elsewhere have already succumbed to pressure from anti-abortion groups to deny permits to abortion clinics, which has left communities without accessible abortion care.[15] Coordination across the region, across agencies, and across sectors can mitigate and prevent harms from the hostile national environment.

Reproductive rights and freedom are protected and actively supported in the Bay Area. And as we will see, the region is home to a robust community of reproductive healthcare providers, stakeholders, and advocates. However, the national anti-abortion movement still poses a threat to reproductive rights, freedom and access in the region.

ANTI-ABORTION PROTESTS

Anti-abortion demonstrations and protests are present and persistent throughout the region. They are particularly disruptive at certain clinics. Community stakeholders, clinic staff, and physicians all reported that the threatening character of protesters increases fear and stigma for women entering their facilities to receive reproductive healthcare. More systemically, demonstrations make it difficult to open new abortion clinics. Many recommended that laws protecting clinics should be bolstered and better enforced.

CRISIS PREGNANCY CENTERS

An investigation by the nonprofit news agency CalMatters found 176 Crisis Pregnancy Centers (CPCs) operating in California, of which 19 are located in Bay Area counties. Per the American College of Obstetricians and Gynecologists, "CPC is a term used to refer to certain facilities that represent themselves as legitimate reproductive healthcare clinics providing care for pregnant people but actually aim to dissuade people from accessing certain types of reproductive healthcare, including abortion care and even contraceptive options." Many are affiliated with national anti-abortion organizations.[16]

About half of CPCs in California are medically licensed facilities, even though many offer minimal medical services. Not a single CPC in California offers contraceptives.[17] These centers sometimes appear on reproductive healthcare resource lists published by government public health departments, with no information that these centers give scientifically inaccurate health information to patients and do not provide contraceptives or abortion, fundamental components of reproductive healthcare. There have been some reports in California that local jails and prisons are referring people upon release to CPCs, rather than to full-service healthcare providers.

TABLE 1.1: ABORTION CARE CLINICS AND CRISIS PREGNANCY CENTERS IN THE BAY AREA, BY COUNTY

	Abortion Clinics	Crisis Pregnancy Centers
Bay Area Region	**50**	**19**
Alameda	9	4
Contra Costa	9	3
Marin	1	1
Napa	1	1
Santa Clara	10	5
San Francisco	9	2
San Mateo	7	1
Solano	2	1
Sonoma	2	2

Resources: Know Your Rights And Find Legal Assistance

The rapidly shifting legal landscape, the rhetoric around abortion, and the anti-abortion movement's efforts to outlaw abortion nationwide have generated fear and confusion among a wide swath of the public about their reproductive rights. For example, the conflicting early court rulings on the mifepristone case led people in California to believe that medication abortion was banned.[18] This was never the case.

Legal experts interviewed acknowledged uncertainty around some issues but also stressed that the rhetoric from anti-abortion officials in banned states is designed to instill fear and frequently has little legal merit. While legal experts strongly recommend that patients and providers protect the privacy of their medical records and communications, they provided a modicum of reassurance about some of the concerns that are worrying patients and providers. We recommend that BAARC work with statewide or national reproductive law experts to provide a webinar for stakeholders in the near future to explore these topics more fully. On an ongoing basis, BAARC should maintain capacity for rapid response to emerging threats.

As of June 2024, only two laws regulating interstate travel have been passed, and both only apply to the travel of minors. The only one in effect is Tennessee's. Idaho's is under injunction.

No banned state explicitly calls for civil and criminal penalties on the person who has an abortion. Many states explicitly state that the pregnant person cannot be punished. Likewise, it is a long established principle in U.S. law that people may travel between states. Therefore, patients accessing care in a state where it is legal should not fear criminal prosecution. The resources listed below can provide further guidance for people coming to California to access abortion care.

Telemedicine abortion care is more of a gray zone, where the law is unclear or undeveloped, even in states such as California with Shield Laws. Legal experts recommend that patients accessing care via telemedicine should know about the Repro Legal Helpline. Clinicians providing telemedicine should have a 24/7 means of communicating with the patient and should disable the interoperability of electronic health records. Clinicians considering offering telemedicine abortion can request an individualized risk assessment by contacting the Abortion Defense Network or SoCal LARJ. (See Resources below.)

Abortion Defense Network (ADN) is a collaborative of law firms, national nonprofits, and governments established to provide legal services and funds to abortion care patients, providers, and advocates to protect and defend their legal rights. Law firms providing pro bono services are trained to handle abortion related cases. All of the national litigating organizations,

such as Center for Reproductive Rights and the ACLU, are members of the network. ADN works on an intake model; staff review inquiries and match people with the appropriate organization or law firm for assistance. Providers and supporters can make a request for assistance through the form on their website. Abortion care patients with questions about their legal rights and legal exposure should contact the **Repro Legal Helpline**, operated by If/When/How. Contact information is available on the Abortion Defense Network website, at https://www.reprolegalhelpline.org/ or by phone at 844-868-2812.

Southern California Legal Alliance for Reproductive Justice (SoCal LARJ), housed at UCLA Law's Center for Reproductive Health, Law, and Policy, provides pro bono representation concerning abortion and other reproductive justice and rights issues. It fields questions and makes legal referrals for people experiencing a whole range of reproductive justice issues, including abortion care. Although based in Los Angeles, SoCal LARJ serves people across California and the United States. Forty-eight law firms with a Los Angeles branch or based in Los Angeles and 15 community partners participate in this network. SoCal LARJ works on an intake model: a dedicated staff member reviews inquiries to identify the specific legal issues of a case in order to match the person with a law firm with the relevant expertise. They are connected to the Abortion Defense Network and other local legal networks and will refer cases onto those when appropriate. To set up an intake call with SoCal LARJ, send an email to larj@law.ucla.edu or call their hotline and leave a message at (310)-206-4466.

Legal Alliance for Reproductive Rights (LARR), convened under the auspices of the Bar Association of San Francisco (BASF), is a clearinghouse for 70 local law firms to provide pro bono legal services to patients, providers, and advocates regarding abortion care or reproductive rights. They take cases from around the country. To connect with a legal expert, email LARR@sfbar.org or call (415) 875-7076.

California Abortion Alliance describes itself as a network of "legal, health, and allied communities to protect and advance access to safe, legal abortion care in California, bridging the gap between abortion law, policy, research, and service provision." Membership is not publicly listed, for reasons of privacy and security. On the Alliance's publicly available resources page, you can find an extensive list of organizations, research, and resources related to abortion access, gender, and other SRH topics. Use the form on their site to contact them.

TeenSource.org is an initiative of Essential Access Health. The site provides resources and information aimed at and accessible to teens and youth about sexual health, relationships, LGBTQ+ issues, and where to get abortion care, birth control, and STI tests.

Center for Reproductive Rights (CRR) is a leading global reproductive rights legal organization. CRR is a member of the Abortion Defense Network and litigates some of the most consequential abortion rights cases in the U.S. The resources page on their website

includes a wide range of useful information, from guides for medical professionals to current tracking of state abortion bans. Requests for legal assistance should be channeled through the Abortion Defense Network website, at https://www.reprolegalhelpline.org/ or by phone at 844-868-2812.

The ACLU maintains a website on the legal right to abortion care and other reproductive health services in California. It includes sections on Minors, Confidentiality, Insurance, Employment, and more.

California's **Office of the Attorney General**, Reproductive Justice Unit, provides a number of useful resources to the public, including DOJ Consumer Alerts, Legal Bulletins, and Investigations. Most Bulletins contain sections on best practices for training of law enforcement personnel and district attorneys. The site can be particularly useful for staff in government agencies who are seeking guidance on implementing California's many new laws on abortion care and SRH access.

PART 2

Comprehensive Sexual And Reproductive Healthcare

A Primer

FIRST PRINCIPLES: REPRODUCTIVE RIGHTS, FREEDOM, AND JUSTICE

Sexual and reproductive health and rights cannot be achieved and maintained without protection of certain human rights. At the same time, sexual and reproductive health is recognized as a right itself and is enshrined in the UN Convention on the Elimination of All Forms of Discrimination against Women (CEDAW).[19]

The Guttmacher-*Lancet* Commission on Sexual and Reproductive Health and Rights advances a broad conception of sexual and reproductive health and rights as "a state of physical, emotional, mental, and social wellbeing in relation to all aspects of sexuality and reproduction, not merely the absence of disease, dysfunction, or infirmity." It goes on to propose that "All individuals have a right to make decisions governing their bodies and to access services that support that right." The Commission enumerates specific sexual and reproductive rights, including the right to bodily integrity, privacy, and personal autonomy; to freely define

sexuality, sexual orientation, and gender identity; and to choose "whether, when, and by what means to have a child or children, and how many children to have."[20]

American communities of color and historically marginalized groups have advocated for many years for the principles of reproductive justice, which SisterSong, a Reproductive Justice collective formed in 1997, defines as: "The human right to maintain personal bodily autonomy, have children, not have children, and parent the children we have in safe and sustainable communities."[21] The concept of reproductive justice stemmed from their analysis that the abortion rights movement's focus on "choice" historically reflected the perspective of middle class and white women and ignored the experiences of women of color.

The contemporary American movement for reproductive freedom, rights, and justice has largely embraced these expansive conceptions of sexual and reproductive health and justice. In the new post-Dobbs environment, there is an opportunity to reassert these principles and forge a new narrative and practice. Municipalities, counties, and states seeking to implement best practices on comprehensive sexual and reproductive healthcare would benefit from setting as a goal of the services they provide this more expansive and comprehensive definition of sexual and reproductive health and rights.

Abortion is, thus, part of a continuum of comprehensive sexual and reproductive healthcare (SRH). An important step to providing high-quality, affordable, equitable, and accessible abortion care is to understand its connections to other services and care, as outlined in the sections below.

CONTRACEPTION, FAMILY PLANNING, AND PREVENTIVE SRH CARE

One way to help women avoid pregnancy is through access to contraception and family planning. Contraception and family planning are preventive services that under the Affordable Care Act are guaranteed to women with insurance at no cost. Women should have access to the full range of contraceptives approved by the Food and Drug Administration (FDA) and should receive adequate education about their options so they can make an informed decision about the type of contraception that is best for them. Other preventive care covered by the ACA includes regular check-ups, reproductive cancer screening, immunizations, blood pressure screening, HIV screening, and STI counseling. In California, insurance programs (which must cover abortion care) also support coverage for sexually transmitted infection testing and all methods of birth control without referral; these services can and should be offered at the time of abortion care.

OBSTETRIC CARE

In the U.S. about 24 of 100,000 women die in childbirth or pregnancy-related causes, more than three times the rate in most other high-income countries. Black women are three times more likely than White women to die of pregnancy-related causes.[22] Preventing undesired

high-risk pregnancies through contraception and abortion care is a key strategy to ensure public health.

States must pay particular attention to racial disparities in maternal care and take proactive measures to address structural racism through systematic data collection and training for healthcare providers. Adopting equity-centered models of care, like reimbursing care provided by doulas and midwives and increasing access to options like free-standing birthing centers and group prenatal care, also helps reduce disparities.[23] Expanding and investing more in the healthcare workforce, particularly primary and pre and postnatal care providers, helps to improve access to reproductive care.

Since 2020, five labor and delivery units have closed in Bay Area counties (Napa, San Francisco, Santa Clara, Solano, and Sonoma).[24]

Options counseling at the time of abortion care may sometimes elicit ambivalence or the desire to continue a pregnancy. Providers of abortion care frequently lack easy linkages for patients to obstetric care, thus leaving care siloed. This has the potential to impact the health of pregnancies since early prenatal care is linked to better outcomes. For example, the Pregnancy Risk Assessment Monitoring System (PRAMS) study found, in 2022, that patients experienced a two-week lag between learning they were pregnant and receiving their first prenatal appointment. In this study, BIPOC women learned of their pregnancies later and established prenatal care later, risking delay in care for underlying conditions.[25]

PRIMARY CARE

Primary care is widely regarded as the backbone of a well-functioning healthcare system. Effective primary care, and lasting relationships with primary care providers (PCPs), improves reproductive health. Some internal medicine and family medicine physicians also provide abortion care within their primary care practices.

Evidence shows that the strong relationships PCPs develop with patients lead to better health outcomes and lower per capita health costs. Among industrialized countries, the U.S. has one of the lowest supplies of primary care clinicians, who are most people's first and most constant point of contact with the healthcare system.[26] The supply has decreased dramatically over the past decade.

Abortion providers may lack resources for patients who present for abortion care with medical concerns because patients are coming from out-of-state or do not have insurance coverage. Abortion care is an opportune time to intervene on neglected conditions. Nevertheless, resources for the underserved or underinsured may be limited.

MENTAL HEALTH

In the context of restricted abortion access, the United States needs to be prepared for a worsening mental health crisis. The mental health system is already overwhelmed by conditions exacerbated by the COVID-19 pandemic, and many women continue to struggle with mental health issues during and after pregnancy. Postpartum depression impacts nearly one in nine people in the U.S., and it is particularly common among low-income women and mothers on Medicaid. Access to antidepressants and other treatment is limited, particularly for Black and Latina women, who are about half as likely to receive postpartum depression care as White women.[27]

Abortion providers may also be well-positioned to intervene on substance use disorders, and screening for the disorders is recommended when patients seek abortion care. However, links to care in this situation are critical to help patients transition easily to the care they need.[28]

THE SOCIAL DETERMINANTS OF HEALTH

The CDC defines the social determinants of health as "the nonmedical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies, racism, climate change, and political systems."[29]

Any plan to address unmet need in abortion care must also consider the social determinants of health and how they can be addressed at the time of abortion. For example, a KFF study of reproductive healthcare in five communities found that, poverty, cultural factors, and social determinants had a considerable impact on women's ability to prioritize, afford, and access family planning or abortion services.[30]

AN ABORTION CARE PRIMER

Nearly two-thirds of abortions that take place in the formal healthcare system are done through medication abortion.[31]

Medication abortion can be safely provided using various protocols. Most providers of medication abortion in California provide care up to 11 weeks of pregnancy. The most effective medication abortion protocol uses two medications. One is a medication called mifepristone, which is a progesterone-blocker that primes the uterus to expel the pregnancy. The other is misoprostol, a prostaglandin that causes the uterus to contract and expel the pregnancy. Patients who select medication abortion can take the medications to expel the pregnancy outside of a clinic setting.

The availability of medication abortion post-Dobbs means that clinicians can offer care to women living in states where abortion care is banned or areas where there is a shortage of

abortion services. In 2021, the FDA lifted a medically unnecessary provision requiring in-person administration of mifepristone, opening the way for an expansion of telemedicine abortion. Medication abortion may also be offered in a wider range of settings than procedural abortion, such as via telehealth appointments or in primary care community clinics. Additionally, self-managed abortion via medication abortion has become more common since Dobbs, as women in banned states now have access to several means for receiving the medications through the mail, and services such as Aid Access provide information, hotlines, and assistance in securing abortion pills.

Procedural abortion during the first trimester is typically a quick procedure that can easily be performed in a clinic setting on most patients, whether that be an outpatient primary care clinic, obstetrics and gynecology practice, or a hospital-based clinic. Later in the second trimester, it can involve a more complex procedure that is offered by fewer healthcare providers. The process may take place over two to three days and be offered in either the inpatient or outpatient setting.[32]

Both medication abortion and procedural abortion are highly effective and safe, according to an extensive review of the scientific literature by the National Academy of Sciences. In fact, abortion becomes less safe when extensive state regulations—waiting periods, requirements for ultrasounds, restrictions on medication abortion, and the like—are imposed.[33] Abortion at any stage of pregnancy is safer than a full-term pregnancy and childbirth.[34] It is important to underscore that an abortion can be considered truly safe only if a woman can have one without risk of legal sanction.[35]

There is compelling evidence, moreover, that being denied an abortion has substantial negative health, mental health, and economic consequences.

The most comprehensive study of these harms is the landmark Turnaway study, a five-year longitudinal study on the impact of abortion access on well-being.[36]

The study identified several long-term adverse effects of being denied an abortion. More than 95 percent of people in the Turnaway study who chose to have abortions reported five years later that it had been the right decision for them. Those who were denied abortion were three times more likely to be unemployed, four times more likely to live below the poverty line, and more likely to report being unable to afford basic living expenses. They were also more likely to remain in contact with a violent partner and were more likely to be raising the resulting child alone without family or partner support.

Intimate partner violence (IPV) is often a reason for seeking abortion. Preventing people from terminating unwanted pregnancies conceived with abusive partners can prolong their exposure to such violence.[37]

Clinicians providing abortion care are well-positioned to intervene on IPV, but not if they lack resources or the cooperation of law enforcement. Most large abortion providing organizations screen for IPV, but they may lack the ability to provide a "warm handoff" to care, that ensures the patient is able to access services immediately. The same is true of mental health services. Some providers have implemented co-located services in their health centers, but this requires financial and personnel resources that smaller clinics may not have.[38]

Key Facts about Abortion in the U.S.

- **1 in 4 women** in the U.S. will have an abortion by age 45.[39]
- **94% of abortions** take place within the first thirteen weeks of pregnancy.[40]
- **63% of abortions** are done via medication abortion.[41]
- **98.9% of abortion care patients** identify as women.[42]
- **0.7% of abortion care patients** identify as gender nonbinary, 0.1% as transgender men, and 0.3% as "something else."[43]
- **57% of abortion patients** are in their twenties, 35% are 30 or older, and only 8% are in their teens.[44]
- **Out-of-state patients** account for 4% of abortions in California.[45]

IMPROVING EQUITABLE ACCESS TO SRH FOR TEENS

Adolescents have always faced substantial obstacles to abortion care access, and post-Dobbs abortion bans have exacerbated the challenges they face. Researchers on adolescent health and healthcare professionals who care for them are concerned that teens will have less timely access to care and will be less able than adults to circumvent the barriers to safe, legal, and timely abortion care.

In California, some evidence indicates that schools in more conservative areas of the state are preventing students from attending medical appointments during school hours—a right guaranteed in California to adolescents. Likewise, it is unclear if students in these areas are receiving accurate, evidence-based sex education, as required by law. California's law on sex education is strong, but its implementation varies significantly across different counties and school districts.

To address the barriers teens face, healthcare providers should consider the following approaches:

- Provide flexible hours of operation to accommodate school schedules.
- Integrate health navigators, coaches, or other support providers to assist adolescents in accessing and navigating care services.
- Connect adolescents via smartphone apps with navigators who can answer questions in real time, help locate services, and provide support in navigating access to care, regardless of the coach's location.
- Tailor care delivery approaches to be responsive to the diverse needs of various adolescent subgroups, such as adolescents of color, unhoused adolescents, and rural adolescents.
- Establish alternative payment structures or funding sources to ensure confidentiality and privacy, as traditional insurance billing may inadvertently disclose confidential services to parents.
- Implement innovative care models, such as mobile vans, that bring services directly to adolescents in their communities, particularly targeting high-risk populations like LGBTQ+ and gender nonconforming teens.

One innovative program addresses the particular obstacles (costs, time constraints, and confidentiality) faced by teens. The Children's Hospital of Philadelphia and Stellar Pharmacy have teamed up to locate a Pyxis ™ medication dispensing machine in the facility where they see teens. These machines can dispense birth control, STI medication, and other SRH needs onsite. By allowing immediate access to prescription medicine, offering various payment options to maintain confidentiality, and reducing the need for follow-up visits or a trip to a pharmacy, the program makes it more likely that teens can access needed SRH care.[46]

> ***"Abortion bans are going to impact our young people for the longest amount of time. We really need to be supporting and mentoring young people around their own coalition-building."***
>
> **– BAY AREA DOCTOR AND ADVOCATE**

PART 3

Reproductive-Age Women in the Bay Area

A Socioeconomic and Demographic Profile

The greater San Francisco Bay Area is home to 7.5 million Californians, of whom more than 1.7 million are women and girls of reproductive age (15-49).[47] This diverse group of women represents nearly a quarter of all people in the Bay Area.

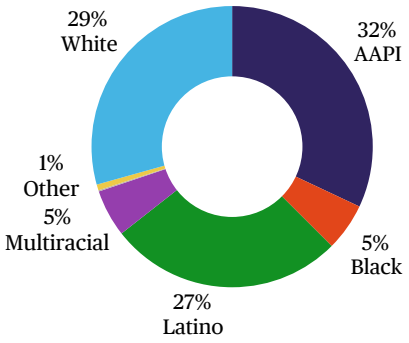
TABLE 3.1: REPRODUCTIVE-AGE WOMEN, BAY AREA

			Women of Reproductive Age	
County	**Population, Bay Area Counties**	**Women (#)**	**(#)**	**(%)**
Bay Area Region	**7,516,588**	**3,746,882**	**1,731,929**	**23%**
Alameda	1,628,905	820,225	397,517	24%
Contra Costa	1,156,414	586,581	260,369	23%
Marin	255,581	131,250	47,043	18%
Napa	134,571	66,790	28,348	21%
Santa Clara	1,871,743	914,096	437,950	23%
San Francisco	808,763	393,766	197,397	24%
San Mateo	729,086	364,152	161,626	22%
Solano	448,753	225,195	99,463	22%
Sonoma	482,772	244,827	102,216	21%

Note: *Percentages are relative to the population of each county and region*
Source: *Gender Equity Policy Institute analysis of ACS 2022*

Nearly a third of reproductive-age women are Asian American or Pacific Islander (AAPI). Latina and White women make up the next largest groups. The ethnic composition of reproductive-age women varies considerably by county. Overall in the Bay Area, 5% identify as Black, with the highest proportion living in Solano and the lowest in Marin. Napa has the highest proportion of Latina reproductive-age women; Sonoma the highest proportion of White women; and Santa Clara the highest proportion of AAPI women.

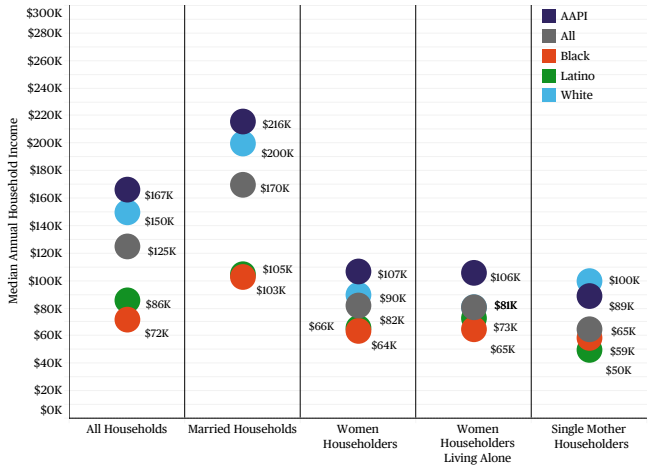
FIGURE 3.1: REPRODUCTIVE-AGE WOMEN, BY ETHNICITY, BAY AREA



There are several factors that impact access to reproductive healthcare, including income and health insurance coverage. Median household income in the Bay Area for reproductive-age women stands at $125,200, but again differs significantly by race/ethnicity, by county, and by family composition.

At the high end, median income is $166,500 for AAPI women and $150,000 for White women. Black and Latina women have lower median incomes at $72,000 and $86,000 respectively. County median incomes ranges from a high of $160,000 in San Mateo to a low of $90,000 in Solano.

FIGURE 3.2: MEDIAN INCOME, REPRODUCTIVE-AGE WOMEN, BAY AREA



Note: *Median household income is estimated for households where women of reproductive age reside. Estimates for certain race/ethnicity and household type categories were not included due to small sample sizes.*
Source: *Gender Equity Policy Institute analysis of ACS 2022.*

In this wealthy region, reproductive-age women also face disproportionately high rates of poverty, with significant racial and ethnic disparities. The poverty rate is highest among Black women (15.4%), followed by Latinas (10.2%). In contrast, just 6.1% of AAPI and 4.9% of White reproductive-age women have incomes below the federal poverty line. County-level data also reveals differences, with Solano having the highest poverty rate among reproductive-age women (9.8%) and Sonoma the lowest (5.8%).

Access to health insurance is another key factor influencing reproductive health. Ninety-five percent of reproductive-age women have health insurance. But coverage differs by race/ethnicity. Latinas have the lowest rate of insurance, at 91%. White and AAPI women have the highest, at 97%.

The teen birth rate in the Bay Area region stands at 6.4 per 1,000, lower than the California state rate (9.8). Rates vary considerably by county and race/ethnicity. Solano has the highest teen birth rate at 10.2 per 1,000, while Marin has the lowest at 3.9 per 1,000. Across all counties, teen birth rates are consistently highest among Latinas, ranging from 10.9 per 1,000 in San Mateo to 16.8 per 1,000 in Solano.[48]

TABLE 3.2: TEEN BIRTH RATE, BY COUNTY, BAY AREA

	Teen births per 1,000 (women age 15-19)
California	**10.3**
Bay Area	**6.4**
Alameda	6.0
Contra Costa	7.3
Marin	3.9
Napa	6.6
Santa Clara	5.3
San Francisco	4.6
San Mateo	6.2
Solano	10.2
Sonoma	7.2

Source: *Adolescent Births dashboard 2019 - 2021, accessed via California Department of Public Health*

Maternal health in Bay Area counties shows notable variation in the prevalence of conditions that can negatively affect maternal health outcomes. (Maternal mortality rates are not reported at the county level.)

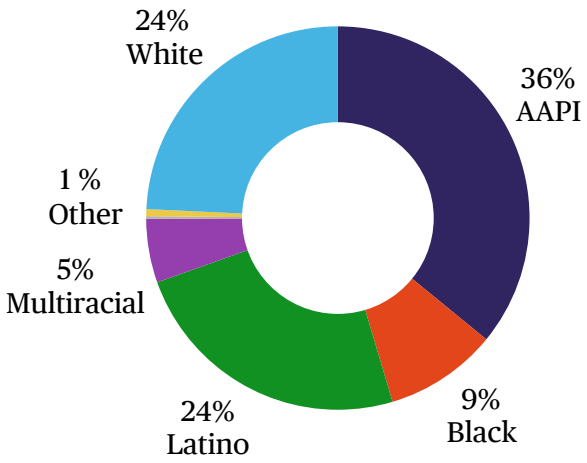
The region reports a slightly higher incidence of diabetes at delivery, with a rate of 14% compared to California's 13.2%. Among Bay Area counties, Alameda exhibits the highest diabetes prevalence at 17.2%, followed by Santa Clara at 16.3%. Marin has the lowest rate at 10.4%.[49]

Similarly, the hypertension rate at delivery in the region is slightly higher than the statewide average, with an average of 18.7% compared to California's 16.1%. Contra Costa surpasses both regional and state averages, recording the highest hypertension rate at 20.9%. Finally, the region's prevalence of asthma at delivery is also higher, with a rate of 9.9%, compared to 6.6% in California. Solano displays the highest rate at 15.6%, while Marin has the lowest at 5.1%.[50]

Alameda

397,517 women of reproductive age live in Alameda

WOMEN OF REPRODUCTIVE AGE, BY RACE/ETHNICITY, ALAMEDA COUNTY



Note: *Percentage of Native Americans alone (with no other combination of race or ethnicity) is below 1%.*

Source: *Gender Equity Policy Institute analysis of ACS 2022.*

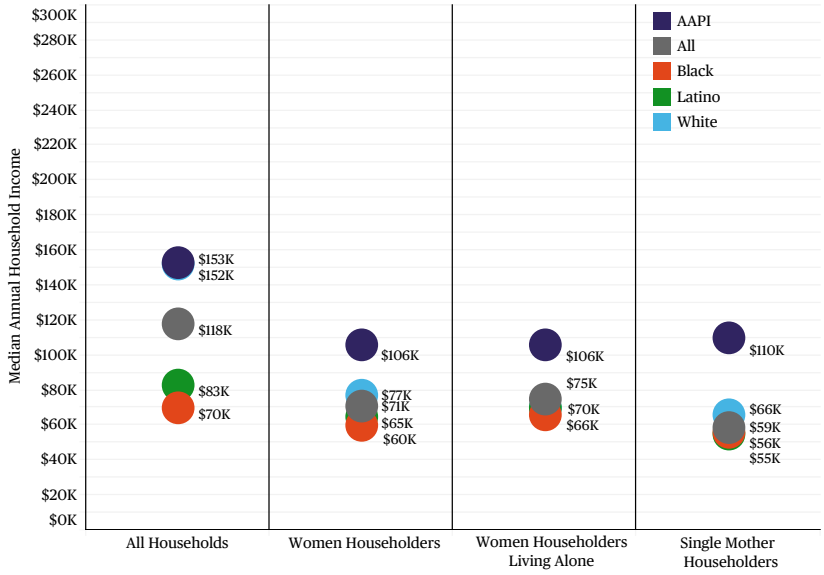
KEY FACTS ABOUT WOMEN OF REPRODUCTIVE AGE (15-49) IN ALAMEDA COUNTY

Share of County Population	**24%**
Parents	**40%**
Insured	**96%**
Insured by Medi-Cal	**18%**
Poverty Rate	**9.2%**

Note: *Parents are defined as having at least one child of their own in the household. Insured is defined as having any form of health insurance coverage, including employer, private, or public plans. Insured by Medi-Cal is defined as having health coverage through Medicaid or any government assistance plan, except Medicare. Poverty rate is defined as living below the federal poverty line.*

Source: *Gender Equity Policy Institute analysis of ACS 2022.*

MEDIAN INCOME, REPRODUCTIVE-AGE WOMEN, ALAMEDA COUNTY



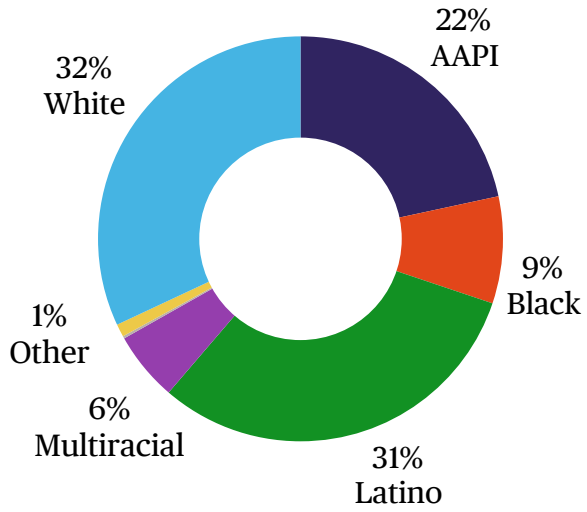
Note: *Median household income is estimated for households where women of reproductive age reside. Estimates for certain race/ethnicity and household type categories were not included due to small sample sizes.*

Source: *Gender Equity Policy Institute analysis of ACS 2022.*

Contra Costa

260,369 women of reproductive age live in Contra Costa

WOMEN OF REPRODUCTIVE AGE, BY RACE/ETHNICITY,CONTRA COSTA COUNTY



Note: *Percentage of Native Americans alone (with no other combination of race or ethnicity) is below 1%.*

Source: *Gender Equity Policy Institute analysis of ACS 2022.*

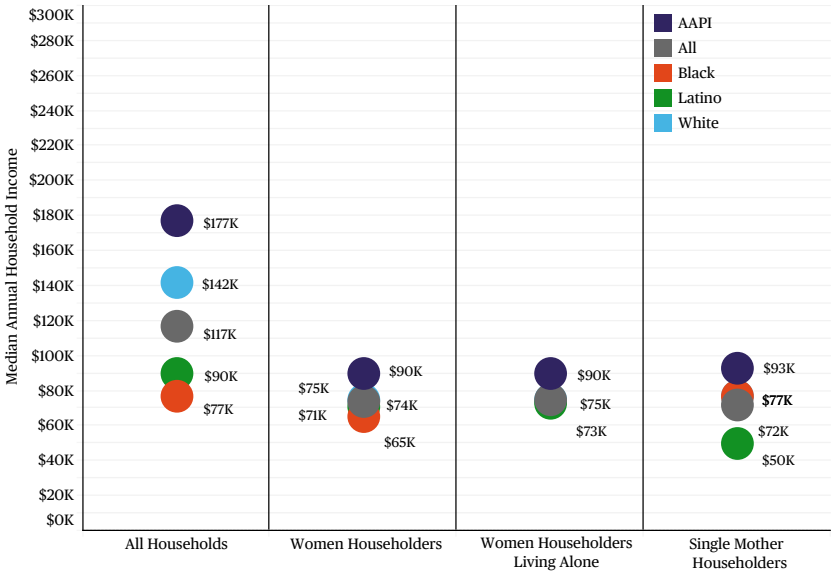
KEY FACTS ABOUT WOMEN OF REPRODUCTIVE AGE (15-49) IN CONTRA COSTA COUNTY

Share of County Population	**23%**
Parents	**47%**
Insured	**94%**
Insured by Medi-Cal	**21%**
Poverty Rate	**8%**

Note:*Parents are defined as having at least one child of their own in the household. Insured is defined as having any form of health insurance coverage, including employer, private, or public plans. Insured by Medi-Cal is defined as having health coverage through Medicaid or any government assistance plan, except Medicare. Poverty rate is defined as living below the federal poverty line.*

Source: *Gender Equity Policy Institute analysis of ACS 2022.*

MEDIAN INCOME, REPRODUCTIVE-AGE WOMEN, CONTRA COSTA COUNTY



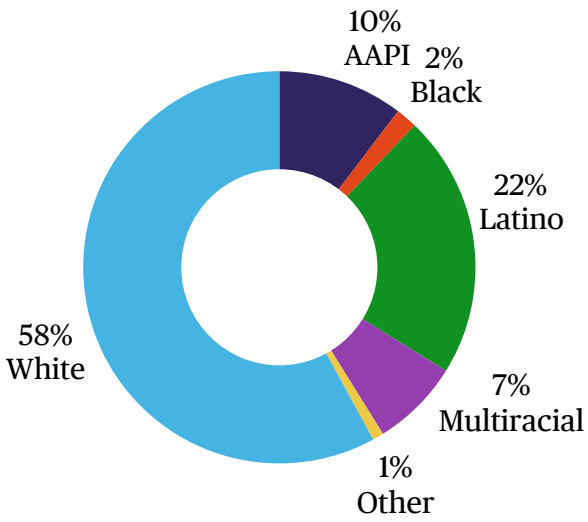
Note: *Median household income is estimated for households where women of reproductive age reside. Estimates for certain race/ethnicity and household type categories are not included due to small sample sizes.*

Source: *Gender Equity Policy Institute analysis of ACS 2022.*

Marin

47,043 women of reproductive age live in Marin

WOMEN OF REPRODUCTIVE AGE, BY RACE/ETHNICITY, MARIN COUNTY



Note: *Percentage of Native Americans alone (with no other combination of race or ethnicity) is below 1%.*

Source: *Gender Equity Policy Institute analysis of ACS 2022.*

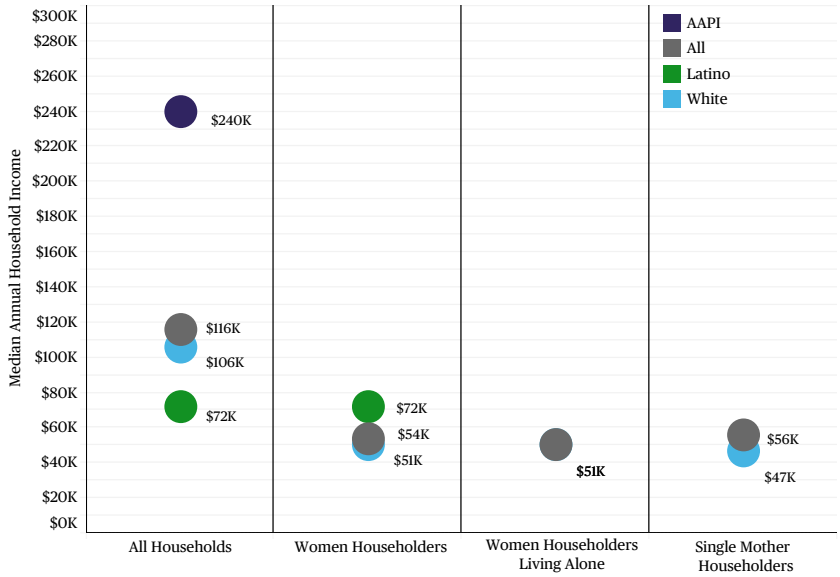
KEY FACTS ABOUT WOMEN OF REPRODUCTIVE AGE (15-49) IN MARIN COUNTY

Share of County Population	**18%**
Parents	**40%**
Insured	**94%**
Insured by Medi-Cal	**16%**
Poverty Rate	**7%**

Note: *Parents are defined as having at least one child of their own in the household. Insured is defined as having any form of health insurance coverage, including employer, private, or public plans. Insured by Medi-Cal is defined as having health coverage through Medicaid or any government assistance plan, except Medicare. Poverty rate is defined as living below the federal poverty line.*

Source: *Gender Equity Policy Institute analysis of ACS 2022.*

MEDIAN INCOME, REPRODUCTIVE-AGE WOMEN, MARIN COUNTY



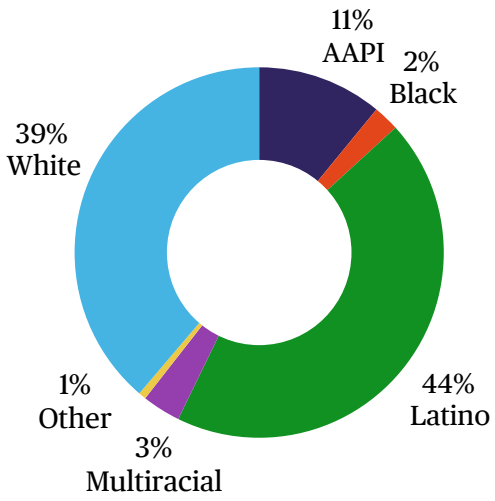
Note: *Median household income is estimated for households where women of reproductive age reside. Estimates for certain race/ethnicity and household type categories were not included due to small sample sizes.*

Source: *Gender Equity Policy Institute analysis of ACS 2022.*

Napa

28,348 women of reproductive age live in Napa

WOMEN OF REPRODUCTIVE AGE, BY RACE/ETHNICITY, NAPA COUNTY



Note: *Percentage of Native Americans alone (with no other combination of race or ethnicity) is below 1%.*

Source: *Gender Equity Policy Institute analysis of ACS 2022.*

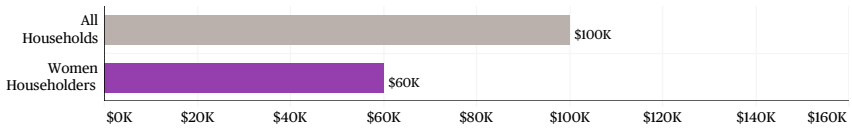
KEY FACTS ABOUT WOMEN OF REPRODUCTIVE AGE (15-49) IN NAPA COUNTY

Share of County Population	**21%**
Parents	**44%**
Insured	**92%**
Insured by Medi-Cal	**19%**
Poverty Rate	**79%**

Note: *Parents are defined as having at least one child of their own in the household. Insured is defined as having any form of health insurance coverage, including employer, private, or public plans. Insured by Medi-Cal is defined as having health coverage through Medicaid or any government assistance plan, except Medicare. Poverty rate is defined as living below the federal poverty line.*

Source: *Gender Equity Policy Institute analysis of ACS 2022.*

MEDIAN INCOME, REPRODUCTIVE-AGE WOMEN, NAPA COUNTY



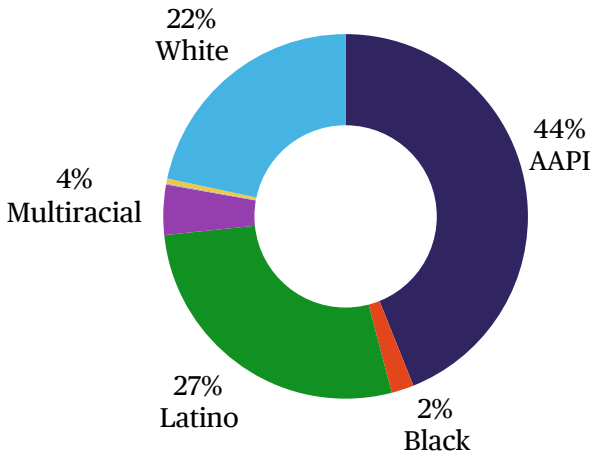
Note: *Median household income is estimated for households where women of reproductive age reside. Estimates for certain race/ethnicity and household type categories were not included due to small sample sizes.*

Source: *Gender Equity Policy Institute analysis of ACS 2022.*

Santa Clara

437,950 women of reproductive age live in Santa Clara

WOMEN OF REPRODUCTIVE AGE, BY RACE/ETHNICITY, SANTA CLARA COUNTY



Note: *Percentage of Native Americans alone (with no other combination of race or ethnicity) is below 1%.*

Source: *Gender Equity Policy Institute analysis of ACS 2022.*

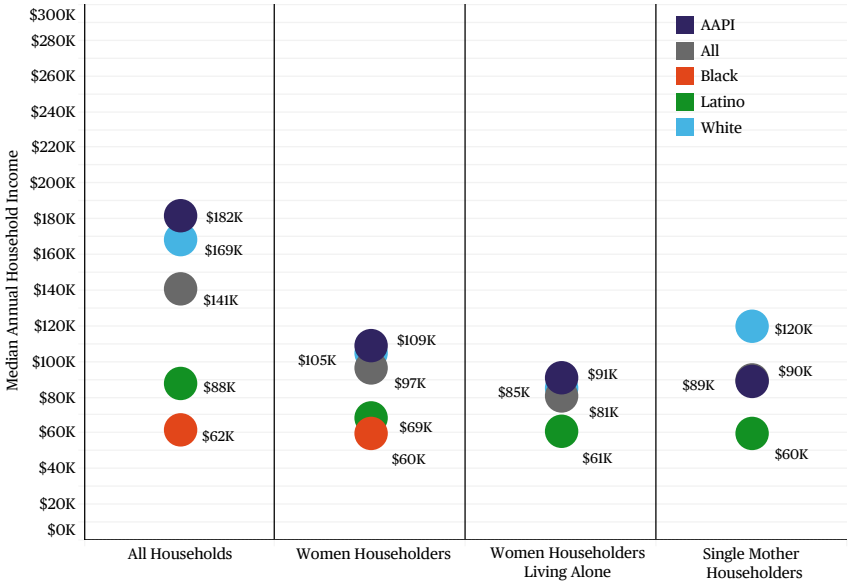
KEY FACTS ABOUT WOMEN OF REPRODUCTIVE AGE (15-49) IN SANTA CLARA COUNTY

Share of County Population	**23%**
Parents	**40%**
Insured	**96%**
Insured by Medi-Cal	**16%**
Poverty Rate	**7%**

Note: *Parents are defined as having at least one child of their own in the household. Insured is defined as having any form of health insurance coverage, including employer, private, or public plans. Insured by Medi-Cal is defined as having health coverage through Medicaid or any government assistance plan, except Medicare. Poverty rate is defined as living below the federal poverty line.*

Source: *Gender Equity Policy Institute analysis of ACS 2022.*

MEDIAN INCOME, REPRODUCTIVE-AGE WOMEN, SANTA CLARA COUNTY



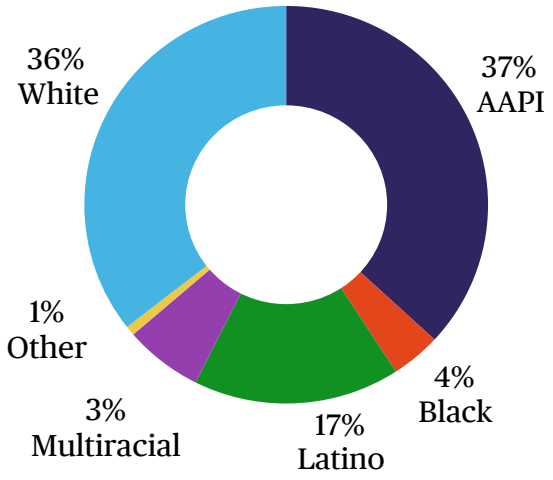
Note: *Median household income is estimated for households where women of reproductive age reside. Estimates for certain race/ethnicity and household type categories were not included due to small sample sizes.*

Source: *Gender Equity Policy Institute analysis of ACS 2022.*

San Francisco

197,397 women of reproductive age live in San Francisco

WOMEN OF REPRODUCTIVE AGE, BY RACE/ETHNICITY, SAN FRANCISCO COUNTY



Note: *Percentage of Native Americans alone (with no other combination of race or ethnicity) is below 1%.*

Source: *Gender Equity Policy Institute analysis of ACS 2022.*

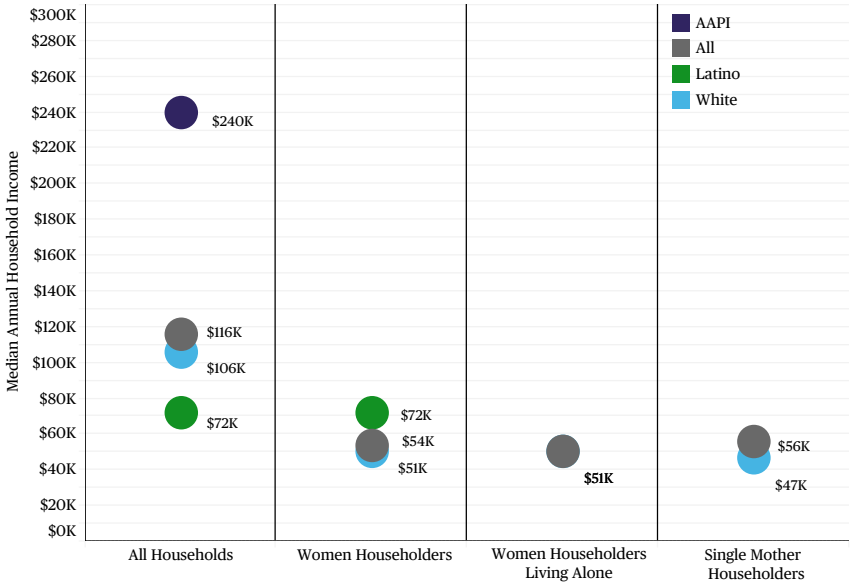
KEY FACTS ABOUT WOMEN OF REPRODUCTIVE AGE (15-49) IN SAN FRANCISCO COUNTY

Share of County Population	**24%**
Parents	**25%**
Insured	**97%**
Insured by Medi-Cal	**13%**
Poverty Rate	**7%**

Note: *Parents are defined as having at least one child of their own in the household. Insured is defined as having any form of health insurance coverage, including employer, private, or public plans. Insured by Medi-Cal is defined as having health coverage through Medicaid or any government assistance plan, except Medicare. Poverty rate is defined as living below the federal poverty line.*

Source: *Gender Equity Policy Institute analysis of ACS 2022.*

MEDIAN INCOME, REPRODUCTIVE-AGE WOMEN, SAN FRANCISCO COUNTY



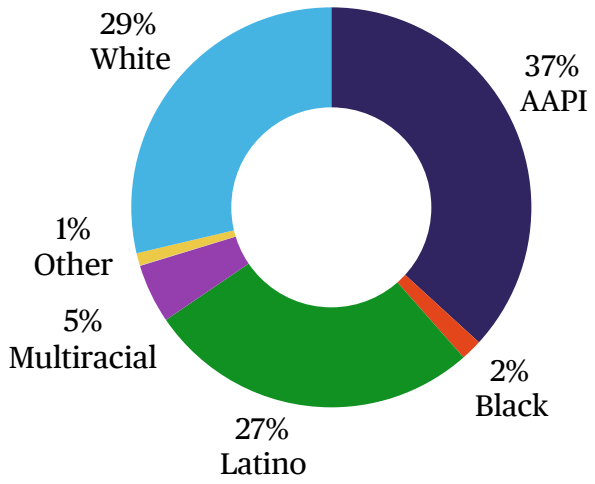
Note: *Median household income is estimated for households where women of reproductive age reside. Estimates for certain race/ethnicity and household type categories were not included due to small sample sizes.*

Source: *Gender Equity Policy Institute analysis of ACS 2022.*

San Mateo

161,626 women of reproductive age live in San Mateo

WOMEN OF REPRODUCTIVE AGE, BY RACE/ETHNICITY, SAN MATEO COUNTY



Note: *Percentage of Native Americans alone (with no other combination of race or ethnicity) is below 1%.*

Source: *Gender Equity Policy Institute analysis of ACS 2022.*

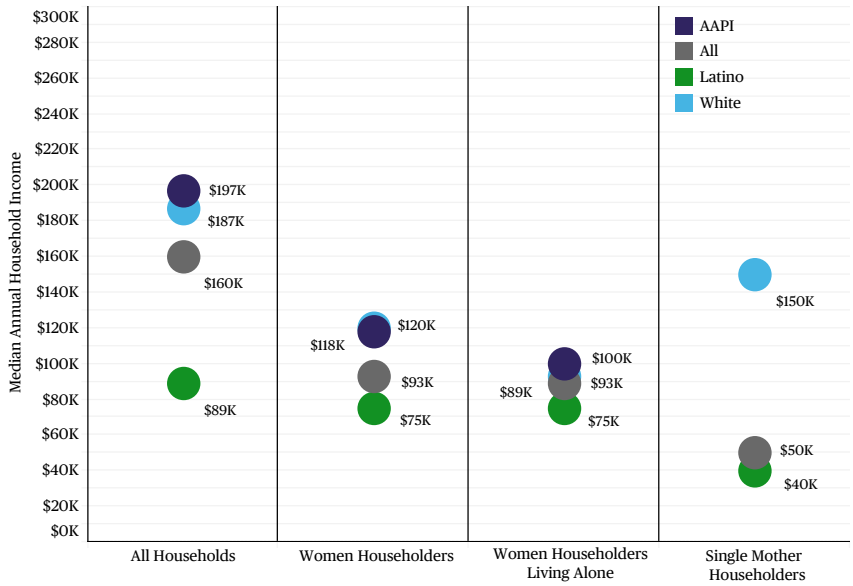
KEY FACTS ABOUT WOMEN OF REPRODUCTIVE AGE (15-49) IN SAN MATEO COUNTY

Share of County Population	**22%**
Parents	**38%**
Insured	**95%**
Insured by Medi-Cal	**14%**
Poverty Rate	**6%**

Note: *Parents are defined as having at least one child of their own in the household. Insured is defined as having any form of health insurance coverage, including employer, private, or public plans. Insured by Medi-Cal is defined as having health coverage through Medicaid or any government assistance plan, except Medicare. Poverty rate is defined as living below the federal poverty line.*

Source: *Gender Equity Policy Institute analysis of ACS 2022.*

MEDIAN INCOME, REPRODUCTIVE-AGE WOMEN, SAN MATEO COUNTY



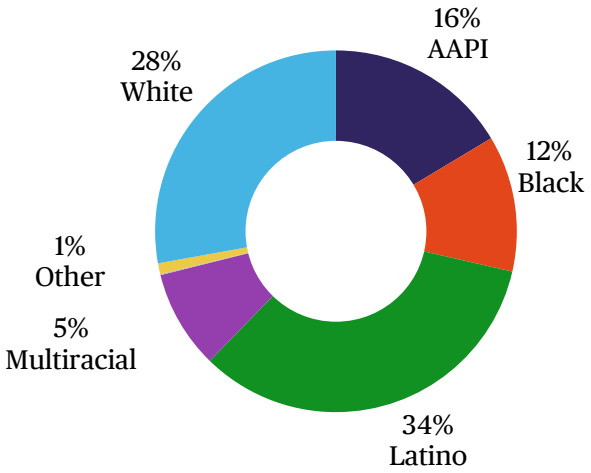
Note: *Median household income is estimated for households where women of reproductive age reside. Estimates for certain race/ethnicity and household type categories were not included due to small sample sizes.*

Source: *Gender Equity Policy Institute analysis of ACS 2022.*

Solano

99,463 women of reproductive age live in Solano

WOMEN OF REPRODUCTIVE AGE, BY RACE/ETHNICITY, SOLANO COUNTY



Note: *Percentage of Native Americans alone (with no other combination of race or ethnicity) is below 1%.*

Source: *Gender Equity Policy Institute analysis of ACS 2022.*

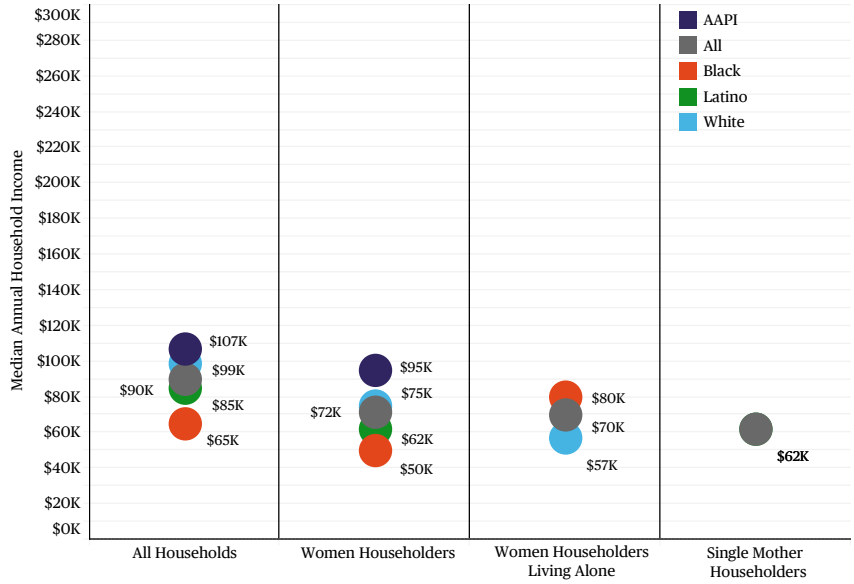
KEY FACTS ABOUT WOMEN OF REPRODUCTIVE AGE (15-49) IN SOLANO COUNTY

Share of County Population	**22%**
Parents	**48%**
Insured	**94%**
Insured by Medi-Cal	**27%**
Poverty Rate	**10%**

Note: *Parents are defined as having at least one child of their own in the household. Insured is defined as having any form of health insurance coverage, including employer, private, or public plans. Insured by Medi-Cal is defined as having health coverage through Medicaid or any government assistance plan, except Medicare. Poverty rate is defined as living below the federal poverty line.*

Source: *Gender Equity Policy Institute analysis of ACS 2022.*

MEDIAN INCOME, REPRODUCTIVE-AGE WOMEN, SOLANO COUNTY



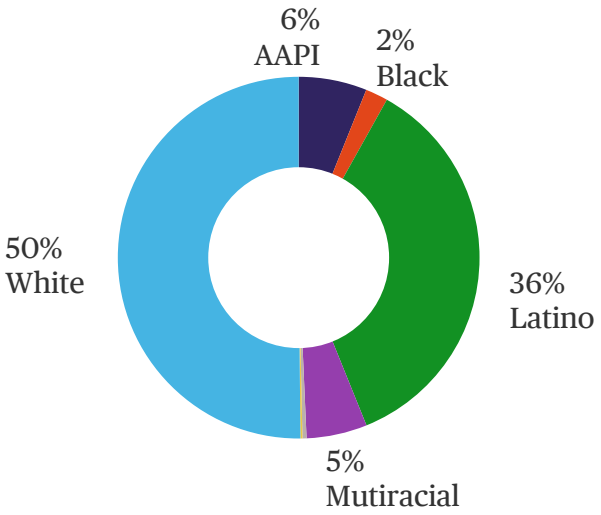
Note: *Median household income is estimated for households where women of reproductive age reside. Estimates for certain race/ethnicity and household type categories were not included due to small sample sizes.*

Source: *Gender Equity Policy Institute analysis of ACS 2022.*

Sonoma

102,216 women of reproductive age live in Sonoma

WOMEN OF REPRODUCTIVE AGE, BY RACE/ETHNICITY, SONOMA COUNTY



Note: *Percentage of Native Americans alone (with no other combination of race or ethnicity) is below 1%.*

Source: *Gender Equity Policy Institute analysis of ACS 2022.*

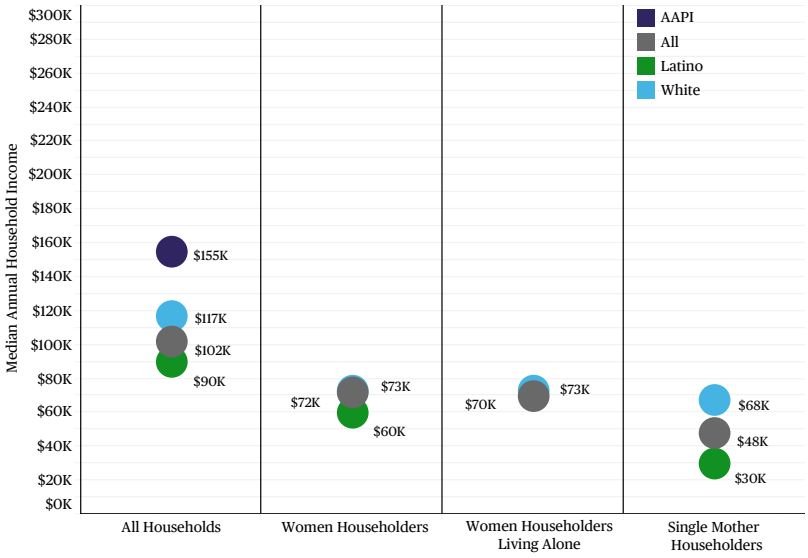
KEY FACTS ABOUT WOMEN OF REPRODUCTIVE AGE (15-49) IN SONOMA COUNTY

Share of County Population	**21%**
Parents	**40%**
Insured	**94%**
Insured by Medi-Cal	**23%**
Poverty Rate	**6%**

Note: *Parents are defined as having at least one child of their own in the household. Insured is defined as having any form of health insurance coverage, including employer, private, or public plans. Insured by Medi-Cal is defined as having health coverage through Medicaid or any government assistance plan, except Medicare. Poverty rate is defined as living below the federal poverty line.*

Source: *Gender Equity Policy Institute analysis of ACS 2022.*

MEDIAN INCOME, REPRODUCTIVE-AGE WOMEN, SONOMA COUNTY



Note: *Median household income is estimated for households where women of reproductive age reside. Estimates for certain race/ethnicity and household type categories were not included due to small sample sizes.*

Source: *Gender Equity Policy Institute analysis of ACS 2022.*

PART 4

Abortion Care in the Bay Area

In the nine counties of the Bay Area, there are approximately 50 clinics, health centers, and medical facilities that offer abortion services. Nearly half are Planned Parenthood Health Centers. Public hospitals and health systems provide abortion care and comprehensive SRH in some counties, such as San Francisco, Alameda, and Contra Costa. Other counties, such as Sonoma, do not operate any medical facilities themselves but do provide information about abortion and referrals to nearby abortion care facilities.[51]

California has an abundance of clinicians and facilities that provide abortion services, but they tend to be located in urban areas, with this geographical disparity affecting access. A dearth of abortion services impacts some of the less urbanized and populous counties in the region. Marin and Napa have only one clinic; Solano and Sonoma have only two. Rural regions in California, like the Central Valley and the Inland Empire, have fewer providers.

Over the past three decades, the number of abortion providers in California has increased significantly, thanks to the expansion of training programs and a shift in medical students' abortion views. Previously, large proportions of residents nationwide opted out of abortion training. Now, OBGYN medical residents are choosing to come to California specifically for abortion care training. The pool of clinicians able to provide abortion care has expanded even further over the last 15 years, with the training of advanced practice clinicians (APCs) such as nurse practitioners and midwives, who under state regulations in California are allowed to offer first-trimester abortion care. Finally, the widespread adoption of medication abortion over the past 20 years has also dramatically increased access to abortion services.

Abortion Care for People from Banned States

Nationwide in 2023, one in five abortions involved women traveling from one state to another to receive care, according to national surveys of abortion care providers conducted by the Guttmacher Institute. In total nationally, approximately 171,000 women traveled for abortion care. Guttmacher's data finds that 6,910 women traveled to California from other states, accounting for 4% of abortions in the state. To put this in perspective, nearly 15,000 women traveled to New Mexico and more than 37,000 traveled to Illinois.[52]

Most out-of-state patients traveled to southern California for care, while a smaller number sought care in the Bay Area. Qualitative evidence from our focus groups suggests that less than 5% of patients cared for in Bay Area clinics were from other states, and many of these patients had family and friends within the region.[53]

Nonetheless, it is important for the BAARC initiative to remain prepared. Although the Supreme Court upheld access to the abortion pill mifepristone in its ruling that the anti-abortion physicians and organizations seeking to block access did not have standing to bring the case, the Court left open the door to future challenges to medication abortion. And as recently witnessed in Arizona, change which could impact California can happen abruptly. In April, Arizona's Republican-dominated Supreme Court upheld a pre-statehood abortion ban, allowing it to go into effect with only a brief delay. California braced for a large influx of patients. However, before the ban went into effect, Arizona repealed the pre-statehood law. Even so, Arizona continues to enforce its 15-week abortion ban and impose numerous medically unnecessary restrictions on care.

In addition, patients may not be aware that they can travel for care and that care is available legally in California. With time, awareness of the availability of funding for procedures and travel may become more widespread and lead to an increase in out-of-state patients seeking care in the Bay Area.

Providing Abortion Care: The Experience of Clinicians and Staff

The overwhelming evidence from focus groups convened by our researchers is that abortion care in the Bay Area is of high-quality and provided with compassion. "The care I personally received was great," said one woman. Another advocate added, "What we've heard is that clinic staff and providers are wonderful." Another added, "The people that do this work are loving, caring people."[54]

Another provider shared how her own experience as a teenager with compassionate reproductive healthcare inspired her to enter the field. "When I went to nursing school, I just quickly realized I didn't really want to work in a hospital, but I was passionate about working with women and underserved populations." After joining a clinic, she continued, "I just fell in love with it really quickly. It's such a special, rewarding, life-changing thing we're doing for people in the course of, like, 10 minutes." Being around "all these compassionate people working there, that inspires me to provide the best care we can."

To prepare for the impact of the Dobbs decision, Bay Area reproductive healthcare centers expanded their facilities, increased staff, extended their hours, and strengthened their connections with communities. While the region's abortion service facilities are currently meeting the needs of patients, the increase in demand for services appears to have put a strain on the capacity of clinicians and the facilities that provide care.

People working on the frontlines of abortion care—physicians, advanced practice clinicians (APCs), registered nurses, patient navigators, community health workers, and other staff—wish they were able to provide more comprehensive health and mental health support to

patients during their visits. "We won't turn anyone away," one clinic staff member explained. "If someone shows up, we don't say, 'Sorry, we're too busy today.'" Instead, they call in one of their clinicians and ask them to drive from one clinic to another, often for over an hour, to make sure the woman receives care that day. "We need to meet our patients where they are and we need to make sure we provide whatever service they need in a timely fashion, and that they walk out of our doors safe, healthy, and with the access and service they need."

But there is simply not enough capacity and time to provide more comprehensive care to each patient, and "the brunt of it falls on the shoulders of our providers." Another added, "We just have this little snapshot into somebody's life for the few hours that they're there. And sometimes you can just sense and tell that they need more support, and you can only really offer so much."

The major challenges faced by clinicians who provide abortion care are summarized here. Recommendations to address these issues can be found in Part 6.

COORDINATION OF CARE

Abortion is an effective and safe procedure that in most cases can be performed quickly during an in-person visit or, in the case of medication abortion, outside a healthcare setting via a short telemedicine appointment.[55] Sometimes, however, abortion care requires greater coordination. "It's not often that we can't see a patient with an underlying medical condition," one clinician noted. "But occasionally, we do have to refer people to a safer setting, like a hospital setting. That just adds another level of complication for the patient, especially if they're already struggling to find childcare."

Coordinating care and ensuring patients get to the right place at the right time and receive the care they desire can be challenging. For example, abortions up to 11 weeks can be done either by medication or procedural abortion. Patients might prefer a procedural abortion but show up at a clinic that only provides medication abortion. Patients may believe they are in the first trimester of pregnancy but are later in pregnancy and require additional appointments in order to receive care. Although online resources such as abortion.gov.ca include information about what services are offered at a clinic, a patient still may not have enough information to know what is best for their situation.

> ***"What motivates me is that this is a unique specialty within healthcare of meeting someone who is often in a moment of vulnerability. To be able to meet that person with a kind of presence and compassion, and then to be able to offer them a procedure in the space of 10 minutes that will literally change the course of their lives, you don't get much greater satisfaction in medicine, I think, than that. It's so rewarding."***
>
> **– BAY AREA ABORTION CARE CLINICIAN**

Patient navigators and other clinic staff, who are responsible for helping transfer patients or arrange travel for them, are invaluable for coordinating care and post-abortion logistics. Unfortunately, there are not enough people in these roles.

Better and more streamlined coordination of care is particularly needed for medically complex cases and high-risk patients. One physician in the Bay Area described a situation of receiving messages from colleagues about complex medical cases; she then personally managed the logistics of getting the patients to the right facility, because there were not enough coordinating staff to help. It also appears that the Bay Area needs greater capacity to treat patients with medically complex needs and/or needing an abortion later in pregnancy.

HARASSMENT

As we have already seen, protests at facilities providing abortion care create an intimidating and insecure environment for patients, staff, and providers.

In addition, people providing abortion care face online harassment, doxxing, and threats at their homes or other places of work. When their identities are publicly known, they can at times need security at their homes or ways to prevent the public disclosure of their home address. Existing state programs are difficult to enroll in and not tailored to their needs. For example, the Safe-at-Home program was established to protect domestic violence survivors from their abusers. Abortion care providers may enroll in the program for the same protections, but the application has to be filed in person at a domestic violence shelter.

REIMBURSEMENT RATES

California is one of nine states that require private insurance plans to cover the cost of abortion without referral, co-pays, deductibles, or cost-sharing. It is one of six states that use state funds to cover abortion costs for Medicaid (Medi-Cal) recipients.

Under current law, California covers abortion at no-cost to patients with Medi-Cal insurance. However, low reimbursement rates put a financial strain on abortion care clinics and providers and reduce abortion care access throughout the region and state. According to an analysis by KFF, reimbursement rates in California are below the median for states that cover abortion services for Medicaid enrollees. In addition, among these states, California and Alaska were the only two that did not increase reimbursement rates between 2017 and 2023.[56]

CONCERNS ABOUT LEGAL EXPOSURE

As previously discussed, California has enacted shield laws and other measures to protect people who provide abortion care from criminal or civil liability. Yet, there is widespread uncertainty among abortion care providers about whether or not certain actions are protected or the laws will withstand legal challenge. As one SRH expert noted, “One of the biggest questions of the Dobbs era is, ‘What are the legal protections for providers? What does it mean to be a doctor in California who sends pills to Texas?’ No one really knows the answer.”

Providers are also concerned about the privacy of their patients' medical records and the security of their communications. Many of these fears concern providing in person or telemedicine abortion care to residents of banned states. Legal resources are available to advocates and healthcare providers in this situation (see Part 1).

An additional and pressing issue for California concerns the law on abortion later in pregnancy. Although California abortion law allows for a physician to make a determination regarding the necessity of abortion care for a patient's health and safety, the law is vague and open to interpretation. This places an undue burden on physicians to decide in certain situations whether they can provide appropriate care. It is also unclear whether there are or are not gestational limits for abortion in California. The law holds that abortion can be performed up to the point when the fetus is viable outside the womb without extraordinary measures, but the definition of "extraordinary measures" is a vague standard when it comes to medical care.

Supporting Equitable Access to Abortion Care: The Experience of Patients and Advocates

All the evidence examined in our research indicates that women, as well as transgender, and nonbinary people are receiving high-quality, compassionate, and respectful abortion care in the Bay Area from medical professionals and staff who care deeply about their patients and are passionate about their work.

Moreover, the region has a robust network of volunteers and advocates, many of whom have expanded their work post-Dobbs. ACCESS Reproductive Justice, a statewide abortion fund with offices in the Bay Area, nearly doubled their Healthline staff, for example. These dedicated people and anchor organizations help people seeking abortions with logistical support and sometimes financial aid for the procedure and other nonmedical costs, such as travel, lodging, and childcare.

> **The stigma attached to abortion has led to a widespread lack of knowledge about what happens during an abortion and myths about its potential health complications. To reduce stigma it is important to use clear language, as one participant observed: "When people hear you say 'abortion' and not use euphemisms like choice, now all of a sudden, if they have a question, they know that they can talk to you because you said 'abortion.'"**

Governments, healthcare providers, and community and nonprofit organizations in the region have demonstrated their commitment to providing affordable, equitable, and accessible abortion care.

The overriding challenge is making access a reality, given California's dramatic economic, gender, and racial disparities. The time-sensitive nature of abortion, its cultural and political salience, and the stigma associated with it exacerbate the effects of these systemic inequalities.

Nationwide, low-income women and women of color bear the brunt of barriers to abortion and reproductive healthcare. These disparities are also present in places, like California and the San Francisco Bay Area, that protect and support access to abortion care.

Black women and girls are particularly harmed, as a large share live in the South, where abortion bans are nearly universal. It is also because, as one physician noted, "folks who already have been experiencing disparities in healthcare are always the most impacted when more restrictions come down around healthcare."

At least 7 in 10 Black women in the U.S. live in states that ban or severely restrict abortion.[57]

Young women, particularly young women of color, also face higher barriers to access. "Discrimination in the healthcare system is a powerful obstacle that so many of our young people face," one interviewee said. "We know that Black girls and folks of color who want to receive medical services, especially those who have other intersectional vulnerabilities like poverty or being unsheltered, also have received disparate care in our medical systems right here in California."

(It is worth noting here that there are several innovative initiatives in the region to address the systemic inequalities in reproductive healthcare faced particularly by Black women. Programs like the BElovedBIRTH Black Centering in Alameda, for example, offer holistic and comprehensive care, consistent with reproductive justice principles.)

Immigrants experience a number of barriers to abortion and comprehensive SRH access. Many are low-income and not aware that they are eligible for Medi-Cal to pay for abortion or pregnancy-related healthcare, regardless of their documentation or immigration status. Navigating the local healthcare system is challenging for those from countries where healthcare access is universal. Others have had negative experiences with medical professionals or are distrustful of government officials. Language can be a significant barrier, especially if someone is a native speaker of a less commonly used language in the U.S. One advocate observed that Arabic and Vietnamese speakers are particularly impacted by the lack of translation services. Another participant did, however, observe, "We're starting to

see more reproductive justice organizations creating language-specific materials, which is helpful. But there are so many languages and certain languages that we don't have access to translators for, which is creating barriers to folks."

Pregnancy can pose particularly acute health challenges for disabled people, exacerbating their existing medical conditions. In healthcare settings, they can sometimes face barriers with exam tables or weight scales that are not accessible.[58]

Unhoused and justice-involved people experience numerous barriers to access. They may lack identification or health insurance or have limited information about abortion care access. Social workers or probation officers are unlikely to know about the many resources for accessing and paying for abortion care, and people may be reluctant to share confidential information with government officials. People with comorbidities or substance abuse often require more coordination of care. "Patients who are struggling with houselessness or addiction need to be met with a lot of empathy, especially when they don't show up to appointments, or they're being a little resistant to making that appointment," one participant observed. "Going into the community itself, going to shelter spaces or resource fairs, to share information is really important. It's also important to build genuine relationships with community-based orgs that don't focus on [reproductive healthcare]."

It is critically important to note that the digital platforms on which local and California governments provide information about access to abortion can themselves be inaccessible to people without cell phones or regular internet access. One specialist in providing mental health services to unhoused people observed, "People who struggle with houselessness and addiction or low digital literacy are really tired of hearing, 'Go in this Zoom meeting' or, 'Go to this website.' I think it's important to show up, be there in person."

Project Libertas: Abortion Doulas

Project Libertas is a Medi-Cal provider that offers doula services to unhoused women receiving abortion care in San Francisco. They help people navigate abortion services, accompany patients to medical appointments, and provide a space within their center for people to be inside while completing a medication abortion. Established on a Community Health Worker model, Project Libertas is trusted by unhoused people, who often return for help navigating other medical or social service issues.

People with nonbinary, transgender, or gender non-conforming identities can feel unwelcome in some reproductive healthcare settings. One participant noted that the gender-affirming care services at Planned Parenthood are wonderful; however, some other large healthcare providers are not always accepting. "Pregnancy and birth itself is still a very gendered topic," one advocate observed. "There have been improvements but often you're

going into a clinic and folks are being misgendered. They're not being asked pronouns. In a prenatal visit, they're calling you mom without really asking whether you prefer a different terminology. For someone who doesn't identify as woman, female, mother, birthing mother, things like that, it's challenging to navigate the system."

A systemic and comprehensive approach to sexual and reproductive healthcare is ultimately required to address the disparities experienced by people marginalized on the basis of intersecting identities. Here the report focuses specifically on the major barriers to abortion care faced by patients and the advocates and volunteers who assist them. Recommendations to improve equitable and affordable abortion care access can be found in Part 6.

> ***"The fact that California pays for poor people's abortions—that's the most important law you could possibly have."***
>
> **– BAY AREA SRH EXPERT**

THE COST OF ABORTION SERVICES AND PROCEDURES

California law, policy, and public health insurance programs are designed to provide abortion care cost-free to nearly all pregnant people living in California.

Those already enrolled in Medi-Cal are eligible for abortion care at no cost. Medi-Cal includes a transportation benefit that will cover the cost of travel to and from abortion care—but it is not well known and may be challenging to access.

Residents of California who are income-eligible and are not already enrolled in Medi-Cal can get immediate and temporary Medi-Cal coverage through the Presumptive Eligibility for Pregnant Women Program (PE4PW). PE4PW covers the cost of abortion care, for those who choose it. For those who choose to continue their pregnancies, PE4PW covers prenatal and other healthcare services during the Medi-Cal waiting period. Once enrolled in Medi-Cal, health insurance coverage continues for one year after the end of pregnancy. Income-eligible immigrants, regardless of documentation status, are eligible. No identification or proof of residency is required.

Although abortion care is by law cost-free in California, many advocates and providers reported that the logistics of Medi-Cal enrollment or inter-county transfer can be difficult. For those with marketplace or private insurance, privacy considerations or out-of-pocket upfront costs can mean that abortion care is not as affordable or accessible as it is intended to be.

NAVIGATING THE REPRODUCTIVE HEALTHCARE SYSTEM

Many Californians lack knowledge about types of abortion, their rights to cost-free abortion and contraception, and their local reproductive healthcare resources. Just as medically complex cases present coordinating challenges to healthcare professionals, patients can face daunting problems of finding more time off work or arranging childcare or transportation to go to another appointment at a different place. As one advocate noted, "It's reasonable, I think, to ask people to navigate it once. But when they need to be referred out to a higher level of care, I worry that patients get lost there."

These difficulties are compounded for non-English or non-Spanish speakers, for immigrants unfamiliar with the local area and U.S. health insurance systems, and for those who distrust medical professionals or government workers because of past experiences of discrimination or unwanted intervention.

THE LOGISTICS AND NONMEDICAL COSTS OF ACCESS

The evidence suggests that some California patients experience the logistics, the time, and the cost of supportive services to access abortion care as major barriers.

The Bay Area is a large region, with several large counties within it. Given the region's traffic and fragmented public transportation system, it can take several hours for people to get to and from a clinic appointment. Consider the situation in Contra Costa, where only two facilities provide procedural abortion, and both are located in the central portion of the county. Women who live in other areas of the county who need or prefer a procedural abortion have long travel times and limited public transportation to those clinics. Out-of-state patients or those traveling from more distant rural areas of the state often require additional help managing the logistics and cost of their travel, including transportation, lodging, lost wages, and childcare.

Abortion funds and volunteer networks active in the region help fill in the gaps, both with funds for practical support and logistical aid. But additional resources and staff would be required to fully remove these types of barriers.

PROTESTS

The Bay Area experiences a wide range of anti-abortion protests at abortion service facilities. Several participants in our research noted the intensity of protests in Walnut Creek (Contra Costa County), where protesters deploy megaphones and GoPro cameras. A clinic escort volunteer in the San Francisco area observed, "protesters are really intimidating to our patients and to their people accompanying them. It's very emotionally provocative for many of them."

BARRIERS FACED BY OUT-OF-STATE PATIENTS

Out-of-state women often travel alone, without family or friends to provide practical and

emotional support. In contrast, one clinician explained, "A lot of our patients who live here bring a support person with them and have them there for their whole visit through the procedure. It just seems really isolating and terrible to have to fly to another state to get the care you need and then be by yourself."

Out-of-state patients seeking abortion care can experience aggravated financial and logistical challenges. They can fear the legal repercussions facing them in their home states. They can be reluctant to use insurance, even if they have it, out of fear that the records will expose them to legal sanction. (It is worth noting that currently no state holds the person who has an abortion criminally liable.)

Providers empathize with their patients from banned states and want to do more for them. They are, at times, hesitant to use electronic medical records to coordinate care, worried that the information from their medical records could fall into the wrong hands.

Some state funding is available for abortion care for out-of-state patients through the current Uncompensated Care and Practical Support Grants Programs. (Current state funding is due to expire in 2028.) In addition, abortion funds have access to philanthropic and private dollars, which can be used to pay for an abortion procedure and other costs, such as transportation and lodging. ACCESS Reproductive Justice, a statewide abortion fund, reports that most of the assistance requests they have received are to pay for the procedure, not for practical support like travel or lodging.

PART 5

Innovative SRH Practice in Post-Dobbs America

Models and Resources

In this section, we highlight a few examples and models of programs designed to protect rights, improve abortion care access, or advance health and well-being for women, mothers, and babies, with particular attention to current inequities and disparities in SRH access.

LOS ANGELES COUNTY ABORTION SAFE HAVEN PROGRAM

In the wake of the Dobbs decision, the Los Angeles County Board of Supervisors adopted a measure introduced by former state senator Supervisor Holly Mitchell to create the Los Angeles County Abortion Safe Haven (LASH). Its goal is to enhance the abortion care infrastructure and capacity and expand linkages to care and information. State funding

supports the LA Abortion Safe Haven Grant Program, which is housed in the Public Health Department and administered by Essential Access Health. The grants programs support training, community-based education, clinical care, and other activities to enhance equity and access.[59]

LASH has published a wide range of resources, including an Abortion Resource Guide (in twelve languages), a tip sheet on how to pay for an abortion, and a "Reproductive Coercion Guide for Advocates" who work with survivors of IPV. They maintain a website with sections covering the full range of comprehensive SRH, including abortion care, as well as sections on legal rights, misinformation, and other relevant topics.

Participants in LASH noted that it allowed for the formation of new partnerships between abortion and reproductive healthcare providers, doula organizations, and other stakeholders and advocates. Funding opportunities created a "broader tent" by attracting new groups into the network, thus bringing new perspectives and new communities to the work of expanding reproductive freedom and justice in Los Angeles. As one LASH participant said, "It's been an interesting space resourcing each other and thinking through new and adaptive ways to improve access."

ADVANCING NEW STANDARDS IN REPRODUCTIVE HEALTH (ANSIRH), UCSF

Advancing New Standards in Reproductive Health (ANSIRH) is a program within the UCSF Bixby Center for Global Reproductive Health and is a part of UCSF's Department of Obstetrics, Gynecology & Reproductive Sciences. Founded in 2020, ANSIRH conducts multidisciplinary research on issues related to people's sexual and reproductive lives. Their mission statement explains: "Our work is informed by an understanding of the role that structural inequities play in shaping health. We believe in the importance of research in advancing evidence-based policy, practice, and public discourse to improve reproductive wellbeing."

ANSIRH's work has led to supportive federal and state SRH policies, such as requiring insurers to provide a year of contraceptives, California's expansion of the SRH workforce to allow APCs to provide abortion care, and the FDA's lifting of the in-person requirements for medication abortion. The landmark Turnaway Study, on the negative consequences experienced by women denied abortion care, was conducted under ANSIRH's auspices.

Recent efforts at ANSIRH have been focused on advancing reproductive justice. In 2017, ANSIRH launched the Abortion Researcher Incubator to bring scholars of color, scholars from conservative states, and other under-represented groups into the SRH research network. The following year it started the Abortion Care Incubator for Outstanding Nurse Scholars (ACTIONS) to support doctoral and postdoctoral scholars at UCSF School of Nursing.

ABUNDANT BIRTH PROJECT, EXPECTING JUSTICE AND UCSF

The Abundant Birth Project was a guaranteed income program that provided unconditional cash assistance to Black and Pacific Islander mothers. It was designed to address racial disparities in maternal and child health outcomes. Piloted in San Francisco as a public-private partnership with support from Mayor London Breed and funding from the San Francisco Department of Public Health, the program provided $1,000 a month to 150 pregnant and postpartum people. A slightly different version of the program has expanded to four California counties, including Alameda and Contra Costa.[60]

NEW YORK, NY: COUNTERING DECEPTIVE CPC PRACTICES THROUGH PUBLIC EDUCATION

New York City has created a public education and outreach campaign about Crisis Pregnancy Centers (CPCs), facilities that mislead people about the health services they offer (see Part 1). The program includes a mechanism for filing complaints about deceptive practices. Recognizing that women are sometimes attracted by CPCs' promise of free services like ultrasound tests, the program also publicizes information about other places to access medically accurate and rights-supporting services.[61]

AUSTIN, TEXAS: ANTI-DISCRIMINATION LOCAL ORDINANCE

Cities and municipalities within banned states have acted to protect individual freedoms to the extent possible under regressive state laws. These measures to reduce barriers to equitable abortion access can provide a model for local governments located in anti-abortion areas of supportive states. The City of Austin, Texas, for example, prohibits discrimination in employment, public accommodations, and housing against people for their reproductive health actions. The ordinance defines Reproductive Health Action as "an individual's receipt or provision of services or counseling related to the reproductive system and its functions, including, but not limited to family planning services, abortion, birth control, emergency contraception, sterilization, and pregnancy testing; fertility-related medical procedures; or sexually transmitted disease prevention, testing, or treatment.[62]

PART 6

Recommendations for Action

What makes the San Francisco Bay Area Abortion Rights Coalition initiative (BAARC) unique is its regional scope. There are many ways a collaborative that includes government, nonprofits, community-based organizations, and healthcare providers can work together to expand and enhance equitable access to abortion care in the Bay Area.

In the previous sections, the report examined the region's assets and strengths in providing high-quality, affordable, and equitable SRH. It explored disparities and the barriers to abortion care access. This final section presents recommendations for reinforcing and improving equitable and affordable access to abortion care, as well as for providing the community infrastructure and practical support to make access a reality for all. The recommendations below take advantage of the special capacities of BAARC's multi-sector multi-jurisdictional structure.

Many ideas that emerged from focus groups and interviews would need to be enacted by legislation or executive agency action at the state level. Fortunately, in California, statewide policy collaboratives and organizations focused on advancing reproductive freedom, justice, and rights already exist: the California Future of Abortion Council (FAB Council) and the California Coalition for Reproductive Freedom (CCRF). Even if state and federal policy advocacy is not within the main scope of BAARC's work, coalition stakeholders, elected officials, and governments have the potential to be influential with locally elected State legislators and California's Congressional delegation. Therefore, recommendations are included on how BAARC can engage with ongoing policy efforts and collaboratives at the state and federal level.

> ***"With our richness of providers and resources in the Bay Area, I think it would be a really important contribution to help those where access to abortion is limited—within our own communities and state."***
>
> **– BAY AREA SRH EXPERT**

1. Regional Systems Coordination and Information Sharing

A clear consensus emerged among members and potential members of BAARC: the most important benefit of the initiative is information sharing and systems coordination across the region.

Every sector currently involved in BAARC identified opportunities in this area. Staff in county health agencies see the initiative as an important forum for shared learning. Doctors expressed an interest in meeting with other doctors and medical professionals in the region; they also emphasized the need to be consulted on public policy and legislation that affect medical care. Advocates look forward to the breaking down of silos, especially after the isolation of the pandemic years. Care providers in some areas have solved problems that are still being experienced by others; more communication among them can scale these solutions.

Many initiatives within the Bay Area region are successfully targeting systemic and practical barriers to high-quality, affordable, equitable, and accessible reproductive healthcare, of which abortion care is but one component. Providing a forum to share information about how these programs were developed and funded and the metrics used to assess outcomes can enable other members to replicate or adapt them to their community.

ACTIONS:

- Prioritize community engagement, connect with communities through trusted advocates and include community groups as full partners.
- Provide topic-specific trainings (by webinar) to build knowledge and capacity across sectors throughout the region.
- Share information about successful local programs and develop toolkits or topical resource guides to facilitate regional replication.
- Establish mechanisms, such as workgroups, quarterly meetings, and newsletters, to build connections and community among BAARC initiative participants.
- Enlist Bay Area participants and statewide groups like Essential Access Health and CCRF to help expand the coalition.

2. Coordination of Care and Logistics of Access

Throughout the region, the community of healthcare professionals and advocates have already developed innovative solutions; however, efforts are fragmented and siloed. Building an infrastructure for care coordination can help identify and scale these solutions, as well as innovate new linkages.

Clinicians who provide abortion services stressed the need for better coordination of care. This is particularly important for medically complex or high-risk patients. Closely related to the need for medical care coordination is support for managing the logistics of access, whether it is scheduling travel, arranging lodging/childcare, paying for a procedure, or navigating insurance coverage. Advocates and volunteers in the Bay Area have created a robust network to help people pay for and manage the logistics of abortion access. Supporting this existing network should be a BAARC priority.

ACTIONS:

- Create a central hub for care coordination to help ensure patients receive care at appropriate facilities based on their medical needs.
- Develop plans and policies to address the difficulty women and providers have in enrolling in pregnancy-specific Medi-Cal to pay for abortion care, with specific attention to barriers to inter-county use.
- Provide logistical and technical assistance to patient-supporting organizations, such as abortion funds.
- Allocate funds to assist patients with the nonmedical costs associated with accessing abortion care.
- Develop plans to assess region-wide logistical needs and attract funding for practical support from public and/or philanthropic sources.
- Work with agency partners to ensure patients are aware of all resources for care and practical support.
- Channel funding where possible through abortion funds with experience in the region.
- Explore a partnership with other state reproductive freedom and justice collaboratives to innovate translation services for less common languages, via phone, virtual, or app-based services.

3. Security, Privacy, and Legal Protection

Regional coordination on legal issues can be critical in addressing the significant concerns providers, patients, and advocates have about their personal security, digital privacy, and vulnerability to civil or criminal legal action by states that ban abortion.

ACTIONS:

- Coordinate regionally on law enforcement matters, including the Attorney General's Reproductive Justice Unit in BAARC's efforts.
- Conduct assessment of all locations where anti-abortion protests are interfering with care to develop action plans.
- Develop model local ordinances.
- Develop or host training programs for local law enforcement.
- Develop and share guidelines and best practices for permitting abortion clinics.
- Improve systems to protect physical and digital security of abortion care providers.

Protect Abortion Care Delivery against Disruption of Protesters

Protecting clinicians, staff, and patients from harassment and intimidation at clinics is one area where BAARC can play a critical role in education, mutual support, and policy guidance. Many localities might not have the capacity or expertise to develop policies, protocols, and trainings on their own. They can benefit from others in the coalition who have put in place effective security measures or have more robust local policies, such as noise ordinances and buffer zones.

It is essential to involve clinic staff and community stakeholders in plans and protocols for security at abortion clinics facing protests and demonstrations. A police presence can be intimidating and threatening to people with negative experiences of law enforcement in their communities. Police need specific training to understand the complex laws designed to balance free speech rights and clinic safety and access.[63]

Funding to improve data security and secure communications systems at facilities is also an important component of overall security for patients and clinic staff. Improving data infrastructure and security might require additional funds.[64] BAARC could potentially be an effective advocate for the region with the State and private sector funders, which often look to maximize equity and impact by distributing investments more broadly.

4. Outreach, Education, and Communications

Through public health communications, initiatives like BAARC can help ensure that public dialogue about abortion and reproductive healthcare remains grounded in science and evidence.

Likewise, many of BAARC's larger objectives can be advanced through outreach, public education, and communications. Such efforts should be developed in close coordination with the community, as well as with SRH physicians, researchers, and legal experts. Private-public partnerships can be particularly beneficial in this domain.

ACTIONS:

- Publicize more widely the existing resources about abortion and reproductive healthcare in California, such as abortion.ca.gov.
- Conduct public information campaigns and outreach within marginalized communities about the availability of free and low-cost abortion and reproductive healthcare in California, as well as how to access it.
- Develop an information campaign around telemedicine and medication abortion to

help people know where to go when they need to access care, especially before they reach gestational limits.

- Amplify the voices and stories of people who have had abortions.
- Develop a plan to assess whether healthcare providers in the region are receiving comprehensive implicit bias training to ensure that all patients, including those coming from other states, receive care that makes them feel safe and respected, especially considering the poor maternal health outcomes for Black women and other marginalized groups.
- Promote, defend, and amplify a scientific, evidence-based approach to abortion and reproductive healthcare.
- Engage the Bay Area's tech community in reducing disinformation about SRH and abortion on social media platforms and in search results.
- Publicize scientifically accurate information about abortion to counter common myths promulgated by the anti-abortion movement and Crisis Pregnancy Centers.

5. Policy Coordination and Advocacy

The barriers to high-quality, affordable, equitable, and accessible abortion care in the region in many instances can most effectively be addressed at the state level in alliance with other state and local reproductive freedom and justice networks.

ACTIONS:

- Collaborate with existing policy networks, such as the California Future of Abortion Council and California Coalition for Reproductive Freedom, to identify policies relevant to the San Francisco Bay Area.
- Explore designating a BAARC representative to the FAB Council and a FAB Council member to BAARC to facilitate rapid information sharing.
- In advocacy with elected officials, promote the use of a scientific knowledge base in policymaking and decision-making about abortion.
- Include SRH researchers and physicians who provide abortions in crafting policy related to medical procedures in order to avoid vague or difficult to operationalize provisions.
- Require community college student health centers to provide the full range of reproductive healthcare services, including medication abortion, as is now the practice in the University of California and California State University systems.

Methodology

Demographic and Socioeconomic Analysis of Reproductive-Age Women: The Gender Equity Policy Institute (GEPI) analyzed individual-level microdata from the American Community Survey (ACS) 2022, accessed through IPUMS USA (University of Minnesota), to create a comprehensive demographic and socioeconomic profile of reproductive-age women (age 15 – 49) in the nine counties in the Bay Area participating in BAARC. The data was used to estimate the number of reproductive-age women, the percentage with health insurance and type of insurance, the percentage living below the poverty line, and the number and percentage by parental status. All analyses were interacted by gender and race/ethnicity.

To estimate and compare median household incomes, GEPI analyzed ACS household-level microdata by type of household, interacted by race/ethnicity, in Bay Area households where reproductive-age women reside. GEPI used the U.S. Census disaggregated classification of household type to identify women householders, women householders living alone, and single-mother householders.

It is important to note that data from the American Community Survey is reported in binary male and female categories. References to reproductive-age women pertain to those who identify as women in ACS. This binary categorization may not fully capture the diversity of gender identities and could potentially lead to underrepresentation or misinterpretation of certain groups in the analysis.

Bay Area Reproductive Health Indicators: Maternal health and teen birth rate data by county was obtained from the Maternal Health Conditions at Delivery and Adolescent Births dashboards of the Maternal, Child, and Adolescent Health Division, California Department of Public Health.

Interviews and Focus Groups: Between July 2023 and May 2024, Gender Equity Policy Institute conducted structured interviews and focus groups with approximately 75 individuals. Interviewees included sexual and reproductive health scholars, researchers, and practitioners, legal scholars and practitioners, government and agency staff, and national, state, and regional advocates in reproductive health, rights, and justice.

GEPI conducted all stage of focus group research, from study design and participant recruitment through qualitative data analysis. To conduct outreach to potential participants, GEPI first consulted the Bay Area Abortion Rights Coalition and proceeded to identify individuals and organizations involved in reproductive rights and justice, abortion care, wraparound services, or community-based service and advocacy. GEPI then utilized a snowball sample technique to extend the sample. Requests to participate in focus groups were also shared widely through two regional newsletters.

Participants were identified and selected through a double-layer process. Particular attention was given to ensuring groups were diverse and representative by county, race/ethnicity, perspective, and sector or type of activity.

Ultimately five focus groups were convened via zoom. They included abortion and reproductive healthcare providers, community stakeholders, reproductive freedom and justice advocates, and community advocates and service providers in areas such as disability rights, mental health, and homelessness. To ensure meaningful and substantive discussion, participation was limited to eight individuals per session. Participants were offered a stipend of $100.

To ensure privacy and adherence to best practices in research involving human subjects, participants completed consent forms. Participants were guaranteed confidentiality. All information provided by participants was de-identified before analysis. To preserve privacy and confidentiality, the names of individuals who participated in focus groups or interviews have not been shared outside the research team and are not included in the report. No personal health or medical information was collected in the course of this research.

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45 "Monthly Abortion Provision Study" (Guttmacher Institute, November 28, 2023), https://www.guttmacher.org/monthly-abortion-provision-study.

46 Interview with adolescent care researcher, Gender Equity Policy Institute, October 3, 2023.

47 Reproductive-age women is defined as women and girls aged 15 - 49. As noted previously, people who do not identify as women can need access to abortion care. They are not included in this data analysis due to limitations in Census data.

48 Teenage birth rates in this section are from 2019 - 2021. The current teen birth rate in California is 13.6. (Gender Equity Policy Institute estimates of data from CDC, 2022).

49 "Maternal Health Conditions at Delivery," Gender Equity Policy Institute analysis of California Department of Public Health 2022, https://www.cdph.ca.gov/Programs/CFH/DMCAH/surveillance/

Pages/Maternal-Health-Conditions-at-Delivery.aspx

50 Ibid.

51 Office of Data and Innovation-State of California, "Find a California Abortion Provider," California abortion access, accessed May 29, 2024, https://abortion.ca.gov/find-a-provider/index.html.

52 "Monthly Abortion Provision Study."

53 This estimate is based on Guttmacher's data in the Monthly Abortion Provision Study and the evidence GEPI gathered in our interviews and focus groups.

54 The findings in Part 4 are derived primarily from focus groups convened by GEPI and supplemented by interviews we conducted. To preserve confidentiality for participants, focus group data was anonymized before review, and participants will be referenced only through their role or general geographic location.

55 Telemedicine abortion is also being offered asynchronously.

56 Brittni Frederiksen and Alina Salganicoff, "Variability in Payment Rates for Abortion Services Under Medicaid" (KFF, March 28, 2024), https://www.kff.org/medicaid/issue-brief/variability-in-payment-rates-for-abortion-services-under-medicaid/.

57 Natalia Vega Varela et. al., "The State of Reproductive Health in the United States: The End of Roe and the Perilous Road Ahead for Women in the Dobbs Era" Gender Equity Policy Institute, January 19, 2023. https://doi.org/10.5281/zenodo.7548698

58 Stephen Brint Carlton et al., Brief of Disability Rights Organizations and Professors as Amici Curiae in Support of Plaintiffs-Appellees (The Supreme Court of Texas November 21, 2023).

59 For program details, see https://www.essentialaccess.org/programs-and-services/los-angeles-county-abortion-safe-haven-pilot-program

60 "Abundant Birth Project," USCF California Preterm Birth Initiative, 2024, https://pretermbirthca.ucsf.edu/abundant-birth-project.

61 "The New York City Council - File #: Int 0506-2022," accessed May 23, 2024, https://legistar.council.nyc.gov/LegislationDetail.aspx?ID=5669105&GUID=C07CE2B9-2F9D-46E2-9160-B60C15774B47.

62 ORDINANCE NO. 20220721-001 https://services.austintexas.gov/edims/document.cfm?id=389093.

63 "Anti-Reproductive-Rights Crimes Guidelines" (California Commission on Peace Officer Standards and Training, March 2009), https://post.ca.gov/Portals/0/post_docs/publications/Anti-Reproductive-Rights_Crimes.pdf.

64 The State of California has previously provided grants through the Physical and Digital Infrastructure Security Grant Program for Healthcare Facilities, https://www.grants.ca.gov/grants/physical-and-digital-infrastructure-security-grant-df-program-for-health-care-facilities-rfp-extended/.